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ABSTRACT

This newsletter presents five articles focusing on the social development of infants and very young children. The first article, "Sympathetic Behavior in Very Young Children," by Lois Barclay Murphy, gives examples of early sympathetic behavior, traces the development of sympathy, identifies individual patterns of sympathetic response, and considers sympathy in the physical and social context. The second article is "Shame, The Exposed Self," by Michael Lewis. It presents a structural model for defining self-conscious emotions, especially shame, and examines the development and socialization of shame. Next, Susan Crockenberg, in "How Children Learn To Resolve Conflicts in Families," looks at parent child interaction as conflict resolution, the effect of conflict on children's development, and implications for family intervention and research. "Social Development and Integration: Facilitating the Prosocial Development of Typical and Exceptional Infants and Toddlers in Group Settings," by Donna Wittmer and Sandra Petersen, illustrates and provides examples of specific strategies for helping children develop early social skills. The last article is "CHILDSPACE--Creating an Environment of Respect for Infants and Toddlers and Caregivers of Children." In it, Jane C. Warrent and others describe a 10-lesson curriculum for caregivers emphasizing the development of respectful social behaviors in very young children. References accompany each article. (DB)

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Zero to Three

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Sympathetic Behavior in Very Young Children

by
Lois Barclay Murphy

Almost sixty years ago, I began to study sympathy* in American children in nursery school. My interest in the subject had been stimulated by a German work by W. Boeck, *Das Mitleid bei Kindern (Sympathy in Children).* American research on children in the 1920s and 1930s, however, was focusing on mental and physical growth and on "problems" such as fear and aggression. The director of the Speyer School, where I proposed to carry out my study, ridiculed my plan. "You won't get any data," she said. "Everyone knows that children have to be socialized."

I found plenty of data on sympathy in young children. My assistants and I wrote simple records of incidents, like this one, in the two-year-old group:

> Heinrich was on the Kiddie car. Wallis was on the bicycle nearby. Wallis fell off the bicycle, pulled it over on himself. He wiggled and struggled to get out. Heinrich left the Kiddie car, pulled the bike so that Wallis could get out. He rode off as soon as Wallis jumped up. (Murphy, 1937, p. 102)

This concise note recorded both the stimulus that prompted the sympathetic response and the response itself.

We saw many kinds of sympathetic behavior among two-year-olds:

- **Comforting another child:** Giving pats, hugs, and kisses; offering solicitous expressions like, "That's too bad," or "That hurts, doesn't it?"
- **Attempting to remove the cause of another's distress:** Removing a tricycle from a fallen child; uncatching a child's foot; pushing away a child attacking another

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- **Helping a child out of physical distress:** Picking a child up after a fall; pushing a swing when a child cannot make it go himself
- **Protecting a child:** Catching a child as she falls
- **Warning another child:** "You might fall"
- **Suggesting solutions:** Telling an adult to keep a child out of danger; telling a child how to get out of a dangerous situation

*In my dictionary, "sympathy" and "empathy" are equated, and I use the terms alternatively.

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- **Involving an adult:** "Bobby is crying"; "He wants . . ."
- **Asking questions:** "Why is he crying?" "Did it hurt you?"
- **Anxious responses:** Staring with an anxious expression, crying, whimpering.

Other observers have also documented sympathetic behavior. Mary S. Fisher, who recorded stenographically the language of 70 children, ranging from 23 to 74 months of age (median age, 38.5 months), over 216 hours found 169 episodes of sympathetic behavior. Sixteen children asked a crying child why he was crying, and 14 made a sympathetic comment. Seventeen times a child asked a teacher why another child was crying. Six times a child comforted another child. Fifty-two of the 70 children were seen to express sympathy in some form during the period of observation.

Susan Isaacs, a British child psychoanalyst, published a study in 1933 of social development in young children in London. Although Isaacs did not focus on sympathy, her report included records of sympathetic behavior, like the following:

> Harold and Benjie accidentally bumped Paul with a table they were pushing. Paul cried, although not much hurt. Harold ran to get his own handkerchief for Paul and sat down beside him, with his hand on Paul's head, comforting him. He kissed him and sat by him until Paul stopped crying and got up.

Isaacs saw friendliness to other children as having its basis in gratitude for gifts received, a response rooted in the infant's response "to the warm gift of his mother's breast." This is not only the source of generosity and friendly responses, but also of protective and appreciative responses. Feeling what happens to the other as happening to oneself is one root of reciprocity, and the tendency to cooperate with active sharing.

In my own continuing observations of young children and in my reading of others' research, I have found that sympathetic behavior seems related to: 1) the child's developmental stage; 2) individual differences among children; and 3) the physical and social setting in which young children find themselves. As adults search for ways to encourage sympathetic behavior in children, we need to pay attention to all three factors, and to their interrelationship.

The development of sympathy

Martin Hoffman (1976) calls the tendency of newborn babies to cry in response to the crying of other babies in the nursery "empathic arousal"—an innate response that leads to the development of empathy, and that continues to be expressed in crying through the first year of life. Studying children in the second year of life, Marian Radke-Yarrow and Carolyn Zahn-Waxler found that from 14 months on, children try to *do* something to alleviate distress. When a mother in an experimental setting pretended to be hurt and cried, her little girl reached out to pat her, burst into tears, and hid her face in a pillow. An 18-month-old boy

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stroked his mother and asked, "Why, why?" Zahn-Waxler felt that the human organism is "hard wired" to respond empathically.

"Hard wiring" notwithstanding, what an enormous amount of learning and perceptual development have to go on between the newborn's echo of the cry of a nearby baby and the toddler's response to mother's pain! When we search for the foundations of sympathy, we know that not only is the baby at birth able to use all of his senses, and even defend himself from interference with his breathing, but even the *unborn* baby can hear, feel contact and pressure, and remember what he has heard. After birth, the newborn, when offered a choice, will prefer to hear again what he heard in the womb. The newborn wants to be held closely, to continue the cozy closeness to mother that he felt in the womb. This appreciation of close contact, and the need for it, form one basis for the infant's response to any person—father, nurse, or other caregiver, as well as mother. The baby's need for stimulation through hearing the talk or singing of the caregiver is another basis for his response.

Lawrence K. Frank (1966) wrote:

> Apparently the infant has a basic need for tactile contacts and enjoys and benefits from being patted, cuddled, and having intimate relations with the mother. The satisfaction of the need seems essential to developing his confidence in the world or his basic trust, to use Erikson's phrase. In the early tactile experiences, the infant learns the precursors of his later developing sociability, his liking for and response to people, and probably his later capacity for sexual relations.

Similarly Shevrin and Toussieng (1962) noted:

> . . . intimacy and empathy appear to be products of these early tactile fulfillments, which generate some of what we call humanness and the feeling of belonging and being accepted. Through tactile contacts and close, intimate relations, the infant experiences love and affection and learns to respond in similar ways to others. It is worth noting how this basic, organic sensory process provides the foundations and patterns for much of what is later oriented and guided by visual and auditory perceptions.

In India and other "developing" countries, mothers maintain close tactile contact with babies by carrying them in a sling on the hip, or under a sash on the back.

Mothers and babies resonate to each other in many ways. They use their mouths playfully, sticking out their tongues, or moving their lips in different ways (as in the photograph of a nursing mother with her four-month-old son). The mother may echo the baby's cooing or beginning talk ("ma ma"). She may clap her hands at the same pace as the baby kicks. Her capacity to respond in tune with the baby's rhythms, intensity, and timing contributes to what Daniel Stern calls "attunement," an active expression of empathy and a precursor of later-developing helping and cooperation.

The baby learns a great deal, as well, from his mother's response to his distress, as she comforts him when he cries or whimpers. During the early years, the baby or young child may be uncomfortable or distressed when he is hungry, when mother "disappears," when he is bumped accidentally, or during the routines of bathing, shampooing, or dressing. Mother's comforting voice, pats, rubs, and kisses evoke the endorphins in the baby's brain—they actually do make him feel better. Thus the baby absorbs experiences of helpful response to his distress as a normal part of life and internalizes the experience. In time, he not only empathizes with but also *responds* to the distress of mother, and others.

I think we have to say that babies are wired to respond prosocially to a prosocial environment. The baby calls for a response in feeding, bathing, and diapering as well as during play times. I have watched a mother blow on a baby's tummy while she changed a diaper and give him a kiss on the forehead as she returned him to his crib. Parents watch with excitement for infants' responsive smiles and imitations of sounds and words.

Editors' Note:

This issue of *Zero to Three* is about very young children comforting, protecting, and helping other children and adults. (Call this prosocial development—if you must.)

As **Lois Barclay Murphy,** who celebrated her 90th birthday on March 23, 1992, reminds us, adults often fail to recognize the caring impulses and capacities of infants and toddlers. As with so many other aspects of development, we may do better to provide young children with opportunities and encouragement to help each other than to embark on adult-defined agendas of "socialization." For one thing, these may backfire. **Michael Lewis'** careful observations record how the almost involuntary "disgust face" of a parent may humiliate, rather than instruct, a child; **Susan Crockenberg** suggests that "compliance" may not be a useful construct in either research or child-rearing.

Since contemporary infants and toddlers do more and more of their learning about relationships in group settings, the work of **Donna Wittmer, Sandra Petersen, Jane Warren, Carla Oswald Reed, Susan Manker-Seale,** and **Lani Comp** offers invaluable guidance to anyone planning or delivering full-time or part-time group care to very young children. These authors challenge us to enlarge our own adult capacities for self-awareness and empathy, so that we may welcome and value each other and all the children and families we serve.

It is precisely this intimate, active contact, this *loving* care, that institutionalized infants miss. In a clean but totally impersonal foundling hospital I found some infants still reaching out for human contact but others who seemed to have given up on the social world and who were literally dying for lack of responsive care.

The circumstances that evoke sympathy expand as the young child gains experience with the world and its woes. Children two and three years old do not generally respond sympathetically to the sight of bruises, swellings, lumps, and other surface indications of discomfort. Nor do they respond to the sight of people using crutches or to pictures of accidents. But three-year-olds do generally respond sympathetically to the sight of bandages, mercurochrome, scars, scratches, red swellings, or evidence of blindness. They also respond to losses—of toys, food, or mother—and to physical dilemmas, such as being caught in a tricycle, confinement to bed, frustration in activity, and accidents, such as falls. They continue to be moved by crying.

A baby I knew well illustrated the relationship between cognitive and empathic development. He ignored his mother's mosquito bite until he himself was bitten. The next time he saw evidence of a bite on his mother, he asked solicitously, "Bite?" This child's love for his mother and their affective attunement were not enough to arouse concern. He needed personal experience in order to understand. He needed understanding in order to empathize. And he needed affective attunement as well as understanding in order to be concerned about his mother.

Individual patterns of sympathetic response

When we look at individual children, we find great differences in the patterns of their sympathetic responses. Nancy was sympathetic but in a uniquely anxious way. Winifred's sympathy was a blend of affection and fearfulness. Douglas had an aggressive style of jumping to defend another child. Julius was the greatest sympathizer as well as being "the biggest fighter."

Each child had a range of behavior different from the ranges characteristic of other children. Each child responded to a range of stimuli for sympathy that was different from that of other children. In my nursery school research groups, some children had many times as many contacts with other children as was the norm for the group. They were extremely alert to what was happening to other children. Some of these differences seem related to basic differences in children's interest in and attention to people as compared with their interest in the impersonal world. My two great granddaughters illustrate this principle. From early infancy, Rachel smiled at everyone, while Heather, her little sister, was preoccupied with the environment—stretching her neck to see in every direction. Now, at school age, Heather loves math and science while Rachel thinks up nice ideas to please grandmother.

Mothers differ greatly in the way they respond to the needs and distress of their babies. Some mothers

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offer comfort and help quickly while others wait to see how the child will handle distress. Still other mothers let the baby "cry it out." (Research findings suggest that babies whose mothers respond promptly to their crying in the first year grow into children who communicate their needs verbally when they are able to talk.)

Whatever their mothers' and caregivers' style of responding to distress, children will differ in the amount of experience of being helped or comforted that they acquire in the first year or two of life. Some children have skin sensitivities which lead to discomfort; others, through impulsive activity, have more accidents. When these are handled responsively by their mothers, they experience more sympathetic care than do children who do not present so much need for it.

What about the long-term continuity of early sympathy? My early research did not follow the nursery school children through their growing up, but I did know a few of them as young people. Janet was the most sympathetic small child we observed; as a mother, she was seen to be perhaps too anxiously sympathetic with her children. Arthur, also a sympathetic child, as an adult urged me to contribute to the support of Amnesty International. Staughton Lynd, who was a sympathetic boy in nursery school, risked (and lost) his Yale faculty appointment when he went to Hanoi to try to help stop the Vietnam war. A few examples do not prove anything; they merely indicate that the early tendency toward empathy *may* persist, if supported as the child grows to adulthood.

Sympathy in the physical and social context

In order to judge the universality of sympathetic responses in young children and to see the range of sympathetic behavior, we would need to study children from a range of socioeconomic, ethnic, and cultural groups and also to study children in a range of caregiving situations. Most research in this country has studied middle-class young children cared for at home by a parent.

My own observations suggest that sympathetic responses emerge in situations that provide opportunities for them. These opportunities arise from the interplay among factors including the age and groupings of children, their physical environment, and the attitudes and actions of adult caregivers. My nursery school research involved two major groups of middle-class children and another group of working-class children in a public day care center.

- In Group A, 20 children ranging in age from 28 to 38 months, played on the roof of an apartment house, competing for the limited number of swings, tricycles, and other pieces of equipment that could be accommodated there. Jersild's research found a conflict every five minutes in this group. The development of empathy among these children was probably not assisted by the response of one teacher to a child's distress; "Big boys don't cry," she declared.

- In Group B, children's ages spanned a 26-month range. The group included toddlers as young as 19 months and children as old as 45 months. Group B enjoyed a large playground in a vacant lot. At the beginning of the school year, I observed more sympathetic episodes among Group B children, as the older children thought of the youngest ones as "babies" and treated them in nurturing ways. For example, they comforted the little ones with pats and kisses when they were accidentally hit with a ball.

- I found that children from lower-income families in the day care group I observed expressed affection more freely than others.

We need to study children in a variety of care settings, including child care classrooms with 15 or 20 children in one group; family day care, with not more than half-a-dozen children in the home; and traditional, very structured Montessori groups of 20 children, with an emphasis on independence and little or no social interaction. When I visited 50 day care groups across the United States, I saw no sympathetic behavior in a disorganized large group without guidance. Nor did I see any in a very structured group divided into small units under two teachers.

Children need to have the freedom to respond to the distress of others in situations where they can see the occasion for help or comfort. The negative response of the Group A teacher and other instances of cold, abrupt handling are likely to be striking to the observer, but we need to be alert also to an absence of adult examples of sensitive sympathetic behavior. Moreover, some care settings are so organized that incidents of one child's need for help from another child do not occur. Some settings are so dominated by adults that opportunities for a child to respond do not occur.

In the Soviet Union, years ago, cooperation was encouraged in preschool groups by provided materials, like large boards for building, that could be handled effectively only by two or more children. This arrangement could be useful in our own group care, especially where space is limited. Similarly, experience in helping, comforting, and other kinds of sympathetic behavior can be provided by arranging groups so that children have the opportunity to see needs they can meet, as well as a teacher who models and reinforces such behavior.

A caring country

Court records, newspaper reports, and radio and television broadcasts are full of accounts of deprived youth who express their anger in impulsive attacks—sometimes on complete strangers. The larger society reveals its limited sympathy in many ways. To be "professional" is sometimes understood to mean being "objective," systematic, following the rules. But to be a professional *caregiver*, especially of a baby or young child, necessitates warmth, playfulness, and spontaneity in evoking the interest of the baby and encouraging her responses. The baby who is handled sympathetically is likely to become sympathetic.

Our country is a caring country—neighbors help in emergencies; hundreds of organizations collect funds and provide services to meet the many needs that cry for attention. To be sure, these efforts are not enough; we must improve our society's ability to cope with the needs of people and of our environment. To do this, we must give our children the foundations for sympathy from their earliest years.

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Shame, The Exposed Self

by
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Like anger, fear, or even joy, shame is a natural emotion, one that is species specific and one that can be observed in almost all human settings. Unlike the primary emotions of fear, sadness, anger, joy, disgust, interest, and surprise (Izard, 1977), shame is a self-conscious, evaluative emotion. Along with guilt, pride, and hubris, shame makes its appearance in the last half of the zero-to-three age range. Shame and the other evaluative emotions emerge as a consequence of certain thought processes which do not themselves appear until the second half of the second year of life. Shame is not only an intrapsychic event but an **inter**psychic event as well, affecting interpersonal relationships. The experience and expression of shame are likely to be influenced heavily by socialization practices.

Consider the following observation of a two-and-one-half year-old child, taken from *Shame, The Exposed Self* (Lewis, 1992).

We are in one of the observation rooms of my laboratory watching a mother playing with her child. We have asked her to teach the child how to play a particular game. We observe her showing the child how to do the task.

"Look," she says, "take this donut and move it from here to there." The child complies. "Very good. You're a good boy. Now," she says, "take the second donut and put it on this one." In this way, the mother slowly shows how to complete the task. The child watches his mother intently as she both explains and shows the child how the task is done. She smiles occasionally, but her face is serious. She often praises her child with such comments as "Good boy," "You are really clever," or "Smart lad." She now rearranges the problems and presents them to the child. The child takes the first ring and puts it on the wrong shaft. The child smiles and looks up at the mother. The mother looks at the child and hollers, "No, no, no! What is wrong with you?"

Our camera closes in on her face. The expression is one in which the nose is raised, nostrils flared, and we know that we will later score it as a contempt/disgust look. The child looks up at the mother, confused, and turns back to the task. However, his body is now hunched over, his smile gone. He no longer appears interested in what is happening. The mother insists that the child go on. The child reaches for the ring, but, rather than placing it on the shaft, throws it across the room.

The mother's "disgust face" has shamed the child. The child, ashamed, responds with what Helen Block Lewis (1971) called humiliated fury—throwing the ring across the room.

Our second observation is of a three-and-one-half-year-old child.

Rebecca comes into the playroom and sits down with her mother at the table. Rebecca's mother hands her a doll. Unknown to Rebecca, the doll has been designed to fall apart soon after she starts playing with it. She starts to play, showing the mother various parts of the doll, pointing out the interesting aspects of the toy.

After about three minutes of play, the leg of the doll falls off. Our camera zooms in on Rebecca. Her mother looks at her and asks, "What is wrong?" Rebecca does not answer. Her face is turned away. She has hunched her shoulders, and she sits slumped over her chair. She will not look at her mother, although her mother asks her again what is wrong.

Rebecca produces a faint smile, but still she will not look up. After a short time, she puts the doll, with its broken leg, back on the shelf where she got it and sits quietly in front of the toy cabinet, appearing to be staring aimlessly into space.

Rebecca has been shamed. She thinks she has broken the doll, and even though her mother has not said anything to her about the toy being broken, she has withdrawn from the situation, sits alone quietly, does not attend to any activity, and appears to be depressed. Although her mother asks her repeatedly what is wrong, she will not speak.

Rebecca's behavior is markedly different from that of Suzy, another three-year-old. When the doll broke, Suzy brought it to her mother and tried to get her mother to help her fix it. She did not appear depressed; she did not appear withdrawn. Suzy's facial expression and demeanor suggested that she sought to repair the harm she thought she had done. How unlike Rebecca, whose withdrawal, body posture, and lack of speech all inform us of her shame over "her" action.

A vignette from my clinical practice suggests the enduring effects of experiences of shame on adults and their relationships.

A couple came to see me who had been married for some time and who appeared to be having a rough time in their marriage. After they were seated for awhile, the wife turned to me and said, "Doctor, I don't think I can stand it any longer. He is always criticizing me. Everything I do is wrong. I don't feel there is anything I can do that will please him." She continued on like this for a few moments.

I turned to the husband to give him his turn to complain. "Doctor," he said, "I don't know what is wrong with her. Half the time she is depressed, the other half of the time she is furious with me. I don't know what it is that I am doing. Just last night, for example, I said to her, 'Why did you use this tablecloth? It has a big stain on it. Why don't we use another one?'"

The husband had barely finished his narrative when the wife turned on him and said, "There, you see,

Doctor, he's always critical; he's always hostile. He's always dissatisfied with me." The husband turned quickly and said, "No, I simply suggested that we use another tablecloth."

Unknown to the husband, his suggestions shame his wife. She is aware only of his aggressive action. He is aware only that he is making suggestions; he does not realize that his actions may be causing his wife to feel shame. The wife responds to the experience of shame by withdrawal and depression, as well as anger. The husband sees the wife's withdrawal as the withdrawal of love, which causes him to feel shame. Like many others, this couple has created a "shame environment" in which, unbeknownst to either, they both shame each other.

Understanding shame and other self-conscious emotions

In order to understand shame and the other self-conscious emotions, we must remember that whereas simple events can elicit primary emotions (a loud noise can evoke fear, the sight of a mother's face can evoke joy), it is cognitive processes that serve as the stimulus events for self-evaluative emotions. In particular, I hold that self-conscious emotions require the ability to think about the self in specific ways.

Figure 1 presents a structural model for defining self-conscious emotions. Subscripts A, B, and C represent cognitive processes that serve as the stimulus event for the class of self-conscious emotions.

SELF-CONSCIOUS EVALUATIVE EMOTIONS

A. Standards and Rules

B. Evaluation

Success	Failure	C. Attribution of Self
Hubris	Shame	Global
Pride	Guilt/ Regret	Specific

Figure 1
Structural model for the elicitation of self-conscious evluative emotions.

A. Standards, rules, and goals

The first set of cognitive processes has to do with standards, rules, and goals, and the evaluation of one's behavior in terms of these. While the acquisition of standards occurs slowly and continues throughout the life span, the child begins to acquire at least some standards, rules, and goals within the first year or two of life. Standards, rules, and goals are established by the culture in which the child is born.

The young child's behavior provides evidence of the acquisition of standards. For example, the young child learns not to go near the stove or learns not to throw food on the floor. The rules are learned by associating the parent's action (praise or punishment) with the child's action.

B. Evaluation of actions, thoughts, and feelings

The second cognitive process that serves as a stimulus for self-conscious emotions involves the evaluation of one's actions, thoughts, and feelings in terms of the standards one has acquired. The acquisition of standards and the evaluation of one's actions seem to be inextricably linked. As soon as children acquire standards, they begin to evaluate their behavior: Have they succeeded in reaching the standard, or have they failed to achieve it?

While the evaluation of the self's behavior inevitably results in awareness that one has succeeded or failed vis-a-vis a standard, it is still possible to conclude that the self is not responsible for either the success or the failure. If one makes an *external* attribution—that is, that one is not responsible for success or failure—then no further evaluation of the self is necessary. But if one makes an *internal* attribution—that is, assumes responsibility for the success or the failure—more self attributions follow.

It is important to know that the evaluation itself can reflect an accurate or inaccurate interpretation. For example, Rebecca and Suzy both thought, inaccurately, that their behavior had broken the doll in the laboratory. In a more ambiguous example, a toddler in the process of toilet training might stay dry six nights out of seven. This behavior might be evaluated as success or as failure, by child and/or adult. Many factors may be involved in producing inaccurate or accurate evaluations, and we will return to this.

C. Self focus

The third cognitive process involved in self-conscious emotions has to do with **how** an individual focuses on the self—in particular, whether one makes global or specific self-evaluations. A global evaluation refers to the "total self." One reflects, "Because I did this, I am bad." A specific self evaluation, in contrast, focuses on a specific quality or action of the self. "I hit Michael when he took my truck, and I made him cry; I didn't use my words" is a specific evaluation. Notice that in the thought process of a specific self-evaluation, the focus is not on the totality of the self, but upon the specific behavior of the self in a specific situation.

Four self-conscious emotional states

Cognitive processes control the child's attributions of success or failure to meet standards, and whether

the child attributes global or specific features of the self. In the development of self-conscious emotions, the standards themselves are a side issue. What we must remember is that we can talk legitimately about the emergence of a specific self-conscious emotion **only** if a child 1) recognizes a standard; 2) evaluates personal responsibility by making an internal attribution or responsibility; and 3) makes a global or specific self-attribution.

Figure 1 distinguishes four self-conscious emotional states on the basis of the cognitive evaluative processes. Hubris (pridefulness) and shame are the consequences of a *global* self focus and the evaluation of failure. Pride and guilt are the consequences of *specific* self-focus and the evaluation of success.

Shame

As I have suggested above, shame is the product of a set of cognitive activities that includes both an evaluation of one's behavior as a failure to meet standards and a global self-evaluation. The experience of shame is highly negative or painful—perhaps the most painful commonly occurring emotional state known. The intensity of this emotional state, this global attack on the self, is such that all anyone in such a state can do is try to get out of it. The child or adult experiencing shame wishes to hide, disappear, or die.

Since shame constitutes a global attack on the self, people have great difficulty in dissipating the emotion. They use strategies including denial, laughter, displacement, confession, and sometimes depression and rage (Lewis, 1992). For example, the boy in our laboratory used rage as a defense against shame. Evidence suggests that males are more likely to use rage and females to use depression or withdrawal as a response to their shame.

It is important to mention that shame can vary greatly in intensity. Some would argue, for example, that embarrassment is a mild form of shame (Izard, 1977). This seems reasonable, and one type of embarrassment does have to do with negative evaluation of the self. Nevertheless, our own research (Lewis, et al., 1989) reveals that embarrassment is quite different from shame. The best example of this is the case of being complimented. Studying children from 18 to 24 months, we found that when children are complimented about how they look ("Oh, what a pretty dress/shirt you are wearing" or "How pretty/handsome you look"), they show embarrased behaviors, smiling, touching their bodies nervously, or looking at and away from the experimenters. Since these are compliments and not criticisms, the children cannot be making negative self evaluations. Embarrassment here seems to be caused by being the focus of attention.

Guilt

If any self-conscious emotion has been discussed in detail, it is that of guilt. Both the psychoanalytic and the psychological literature have considered this concept in some detail. In their review of the origins of guilt, Zahn-Waxler and Kochanska (1991) use the single term guilt to encompass guilt and shame. Other writers give diverse meanings to the terms "guilt" and "shame." While the definitions offered here cannot resolve these differences, they do allow us a starting point for empirical study.

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The emotional state of guilt or regret is produced when an individual evaluates his behavior as failure, but focuses on the specific features of the self or the self's action that has led to the failure. Unlike the experience of shame, where the focus is on the global self, the experience of guilt leads the individual to focus on the self's actions and behaviors which led to, and, in the future are likely to repair the failure. From a feeling point of view, the individual is pained by the failure, but the feeling of pain is connected to the *cause* of the failure or the *object* of harm.

Because the cognitive attributional processes focus on the action of the self rather than on the totality of self, the feeling that is produced, guilt, is not as intensely negative as shame and does not lead to confusion and to the withdrawal from action. In fact, the emotion of guilt is often associated with ideas for corrective actions that may repair the failure or prevent it from occurring again. The person who is ashamed hunches over in an attempt to hide, if not to disappear. The person who is guilty moves in space, trying to repair his action. The postural differences that accompany

guilt and shame are easily distinguished and help us both to differentiate these emotions and to measure individual differences.

Not surprisingly, these postural differences are especially apparent in young children. In coding our laboratory observations, we classified Rebecca as shamed, but not Suzy. We claim this difference on the behaviors we observed. Rebecca showed body collapse; she could not act coherently; she could not speak—all markers of shame. Suzy, on the other hand, could act, and did try to rectify her failure. These differences, readily observable in young children (Barnett & Zahn-Waxler, 1987), mark a clear distinction between shame and guilt.

Hubris and pride

Language usage is a problem when discussing the self-conscious emotions. We have difficulty not only with the terms "shame" and "guilt," but also with "pride." In English, we lack two terms to characterize pride, although we have two meanings for the term. The first meaning has a negative connotation, suggested by the adjective "prideful." For this idea, I use the Greek term "hubris." To express the second meaning, that of pride that comes with success of a specific action, I use the term "pride" itself. Such a distinction informs us immediately about the relation of these two types of successful self-evaluations.

Hubris is the consequence of success where the focus is on the global self. In this emotion, the individual perceives the total self as successful. Like shame, hubris is unrelated to specific action; unlike shame, hubris is highly positive and therefore emotionally rewarding. Especially in extreme cases, hubris is often associated with grandiosity or with narcissism (Morrison, 1989). Because of the global nature of the emotion of hubris, it is in need of continuous renewing. In order to be able to maintain this state, the individual must either alter standards or reevaluate what constitutes success.

Pride is the consequence of a successful evaluation of a specific action. The phenomenological experience is "joy over an action well done." Here again, the focus of pleasure is specific, related to a specific behavior, thought, feeling, or, frequently, achievement (Heckhausen, 1984). That this positive state is associated with a particular action provides the individual with a ready means to prolong or produce this state: specific achievement. Unlike hubris, pride, with its specific focus, allows for action.

The development of self-conscious emotions

The cognitive evaluative process that I have suggested allows us to consider the role of self throughout the development of emotional life. Such a scheme is useful not only in establishing precise definitions, but also in articulating the processes that underlie the production of these emotions. Because this scheme depends heavily on the emergence of consciousness, it has interesting developmental features.

The developmental model I propose suggests in general that **feeling gives rise to thinking about feeling, which gives rise to new feelings.** The milestones in this process, described earlier in more detail (see Lewis, Sullivan, Stanger & Weiss, 1989), are as follows:

- Within the first six months of life, primary emotions emerge and can be observed (see Bridges, 1932; Sroufe, 1979). This first set of emotions includes fear, sadness, anger, disgust, interest, and surprise (Izard, 1977). Their occurrence is not dependent on self comparison (see Plutchik, 1980, for a similar analysis of the difference between primary and secondary emotions).

- In the second half of the second year of life, the emergence of consciousness occurs (Lewis & Brooks-Gunn, 1979). The emergence of consciousness itself gives rise to the first set of self-conscious emotions, called "the exposed emotions." These include embarrassment, empathy, and envy. These emotions are not evaluative.

- Somewhere between 30 and 36 months, knowledge of standards, rules, and goals emerges. Two sets of cognitive processes—consciousness and standards—are necessary for the emergence of the evaluative, self-conscious emotions of shame, guilt, hubris, and pride.

Because two sets of cognitive processes are necessary, evaluative self-conscious emotions occur later than the simple self-conscious emotions (Heckhausen, 1984; Kagan, 1981). Such a scheme allows us to place the development of consciousness and self-conscious emotions within the first three years of life.

The socialization of shame

The experience of shame depends heavily on socialization experiences. More specifically, individual differences in shame may be accounted for by the standards and goals set by socializing agents and/or by the use of global versus specific attribution. Socialization rules play a direct role in the process of comparing one's behavior to a standard and concluding whether one has failed or succeeded vis-a-vis that standard, rule, or goal. Parents influence the process by which one compares one's behavior or achievement to a standard. For example, a patient of mine reported that however well he scored on an exam, his father was always critical. He recalled coming home with a 97% score on a chemistry test and having his father ask what happened to the remaining three points. Similarly, socialization experiences may affect the likelihood that a child will make a global rather than a specific self-attribution around failure, and feel shame as a consequence. Data from the achievement literature suggest that when failure occurs, females are more likely to make an internal global attribution, and males are more likely to make an external evaluation. Males tend not to blame themselves, and if they do, they are more likely to make a specific rather than a global attribution.

I have attempted to explore this issue by looking at parents' behavior in the context of an achievement test where they were asked to get their three-year-old

children to solve both easy and difficult tasks. We observed that parents made very few global attributions, but those who did were more likely to be negative for daughters than for sons. In the same study, parents were more likely to make specific attributions to sons than daughters, and their specific attributions to girls were more negative than those to boys. These observations suggest that parents may affect both the internal/external and the global/specific dimensions of attribution.

FLORENCE SHARP

"Normal" shame

Like any emotion—anger, fear, or even joy—shame is a natural emotion, one that is species specific and whose appearance and occurrence are to be expected. As with any other emotion, the exhibition of too much or too little shame can be pathological (for discussion of the pathological aspects of shame, see Lewis, 1992). What is important for our consideration here is the knowledge that the self-conscious evaluative emotions—shame, guilt, pride, and hubris—all make their appearance in the last half of the zero to-three age range. The late appearance of these emotions is due to their dependency on self-conscious processes which themselves do not emerge until the second half of the second year of life. Since evaluative emotions emerge as a consequence of certain processes, they are likely to be influenced heavily by socialization practices. The continued study of the socialization of these self-conscious evaluative processes is important, both for the understanding of development and for the treatment of psychopathology of children and families.

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How Children Learn to Resolve Conflicts in Families

by

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A parent says to her two-year-old child, "Eat your dinner," and the child says, "No". Events such as this one are ubiquitous in the lives of parents and young children, and serve as windows to family relationships. In studying them, however, researchers, myself included, have taken a characteristically linear approach, focusing on who will prevail, and more specifically, on whether and how quickly the child will comply. As researchers interested in how children become socialized, we have asked, "What control strategies are most effective in eliciting compliance from the child", "What parental behaviors give rise to a defiant response from the child"? These are important questions to parents and researchers alike. Parents have an immediate and legitimate interest in knowing how best to encourage their children to modulate their own interests and goals in ways that allow other family members to pursue their interests and meet their goals. Whether children bear the primary responsibility for achieving this family goal, as the targeting of their behavior implies, is open to debate.

When a parent issues a directive, or makes some claim on the child's time or behavior, there are several possible outcomes. The child may comply, that is, she may simply do what the parent wants. In most families, this is the most frequent child response. It is also common, especially during the second and third years of life, for children to say, "No," or to otherwise indicate that the proposed plan of action is not to their liking. When this latter response occurs, the parent and child have a conflict. Their goals are incompatible; one person wants one thing, the other wants something else. As is the case in any conflict, resolution requires that one or both of them give up or modify their goals. Viewing parent-child interactions of the sort described above as conflicts and their outcomes as conflict resolutions shifts our perspective of these events in significant ways. Most notably, it introduces the possibility that both parent and child may modify their goals in an effort to achieve a resolution.

Parent-child interaction as conflict resolution

In a 1957 treatise on the question of "yes and no," Spitz recognized the significance of negation, describing it as "the most spectacular intellectual and semantic achievement during early childhood" (p.99). He identified the acquisition of "No" as an indicator of a new level of autonomy that accompanies the child's increasing awareness of the "other" and the "self" during the second half of the second year of life. Spitz noted, moreover, that with the child's assertion, the process of negotiation begins. In response to the child's assertion, the parent may alter her approach, perhaps explaining to the child why he or she should comply, or attempting to persuade him or her to do so. She may attempt to engage the child in the task by making it attractive, or she may put it off temporarily. The child may respond by complying, possibly to a much modified directive, or by rejecting the parent's overtures with another "no," in which case the parent may persist in the first response or try another. There is empirical evidence that this pattern of reciprocal interactions characterizes many parent-child exchanges.

One of the most startling observations we made in the course of our study of 95 mothers and their two-year-old children (Crockenberg & Litman, 1990) was the frequency with which negotiation occurred in the context of a parent's expressed desire that the child pick up the toys scattered around our laboratory playroom and put them in a basket. When children refused, or indicated their reluctance to pick up the toys by continuing to play with them, mothers sometimes repeated their directives, and at other times escalated their demands by increasing the loudness or abruptness of their verbal delivery, or by moving the child bodily first to a toy and then to the basket. Often, however, mothers modified the way they attempted to enlist the child's cooperation so that both mothers and children could obtain their goals. One way they did this was to explain why the pick-up was necessary ("We need to clean up for the next little boy or girl.") or appeal to the mutuality of the relationship ("Could you do it for mommy?") Another approach was to integrate play with toy pick-up. A mother might encourage the child, or participate in "driving" the cars and trucks into the basket, in tossing the block into their container, in placing puzzle pieces into the puzzle, in putting the dolly to bed in the basket and the animals to sleep in the farm. Similar exchanges occurred at home. When a child refused a mother's directive to, "Eat your dinner", a mother might respond with a modified proposal that the child, "Have a bite of hot dog." What each of these strategies has in common is that they combine a statement of the parent's goal with some recognition that the child has a different goal and needs to be invited or enticed to respond to the parent's wishes.

When mothers combined control (a simple directive) with guidance (explanation, persuasion, or enticement), children who had initially refused a maternal control attempt were more likely to comply than when mothers used any single strategy.

Two points are noteworthy about the strategies just described. The first is that they were effective in achieving the mother's goal of having the child put the toys in the basket—our definition of compliance. When mothers combined control, that is a simple directive, with guidance, that is an explanation, persuasion, or

enticement, children who had initially refused a maternal control attempt were more likely to comply than when mothers used any other strategy. Neither control nor guidance alone was as predictably related to child compliance under these circumstances as was their combination. This was so, we think, because control alone emphasizes only the mother's wishes, and guidance alone conveys to the child that an invitation has been issued which can be accepted or rejected at will. When they occur together, they convey that both the adult's wishes and the child's wishes are important. The second point is that in explaining, persuading, and accommodating to their children, they conveyed information to them about the way conflicts with others can be resolved.

How conflicts affects children's development

The process of conflict resolution serves as an arena in which children learn to balance the achievement of their goals with the desires of others to achieve theirs. Relationships in which children are involved with important others over a significant period of time are the most likely contexts for this learning to occur because conflicts inevitably arise, and patterns of interaction around these conflicts will be repeated many times. The achievement is both behavioral and attitudinal. Behaviorally children learn that if another person does not share your goals, you can negotiate—listen to what they want, suggest modifications of what you want that approaches what they want, or simply incorporate what you think they want with what you want. Much of the negotiation that goes on between young children is of this latter type. Like the mothers whose behavior they imitate, the children determine what others want by observing their behavior, and adapting their response accordingly. Thus, a child who wants to play blocks observes that the peer who ignores his overtures is flying an airplane noisily around the room, and she entices him to join her activity by building an airport. Children who exhibit this skill are more effective in entering new groups, and are selected as playmates more frequently than their peers. Attitudinally, children learn from negotiated conflicts that equity in relationships is desirable.

Since children learn relationship skills in families, there should be a long-term developmental payoff for children when parents adopt negotiation as an approach to resolving conflicts between themselves and their children.

That conflict may have desirable developmental outcomes is not an entirely novel idea, although until recently conflict has been widely viewed as a totally negative event (Hocker & Wilmot, 1985). In a 1989 chapter, Shantz and Hobart proposed some ways conflict might function in the development of social relationships and in the development of self. Following Sullivan (1953) and Piaget (1932), they argued that when conflicts between peers include discussion, argument, negotiation, and compromise, they produce more satisfying and enduring relationships because they are based on mutual consent, rather than on submission to authority. I am extending their argument to parent-child relationships. The likelihood of children negotiating with peers is enhanced when their family relationships offer a model of conflict resolution characterized by direct expression of one's own desires, attentiveness to the expressed desires of others, and verbal and nonverbal compromises that allow each member of the dyad or group to achieve their goals to some extent. Family relationships give rise to child peer relationships of a certain character, and children's ongoing experience of both types of relationship shape their relationships with their adult partners and ultimately with their own children. From this perspective, the potential influence of conflict experiences on the child's behavioral development and life course is substantial. The nature of that influence depends, of course, on the way conflict is expressed and resolved in families.

Although conflict need not be synonymous with aggression and hostility, there is considerable anecdotal and empirical evidence that within as well as outside families individuals often attempt to ensure that their position will prevail over others, or that their goals will be achieved, through the use of coercive and even violent tactics. The high incidence of spouse battering and child abuse in this country, and the related estimate that approximately 3.3 million children witness their parents' marital violence annually (Carlson, 1984) illustrate this reality. Verbal coercion is also pervasive, both between marital partners (Gottman, 1979) and between parent and child (Crockenberg & Covey, 1991). Thus, what children learn from their experience of family conflicts depends on the specific behaviors to which they are exposed in their own family relationships.

Implications for family intervention and research

If family conflicts serve as arenas in which children learn relationship skills, there should be a long-term developmental payoff for children when parents adopt negotiation as an approach to resolving conflicts between themselves and their children. It follows that one way professionals who work with families may further the development of children is to help parents develop negotiation skills they may not have learned in their own previous relationships. How this would be done depends on the context in which the work is taking place. Thomas Gordon's books, *Parent Effectiveness Training* and *Teacher Effectiveness Training*, are excellent sources of information about the skills necessary for adult-children negotiation, and parent-education classes, in which adults role-play conflicts they are currently engaged in with a child, are useful vehicles for helping ordinary parents and other adults develop negotiation skills. The fewer the skills an adult has, and the more firmly established are alternate strategies

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(e.g. power-assertive or violent approaches to conflict), the more intensive the intervention will need to be in order to effect change.

The ultimate goal of the intervention, of course, is to help children learn strategies they will use in their own relationships with peers and partners. When children have grown up in families characterized by high levels of power assertion or avoidance of conflict, they may have failed to develop appropriate negotiating skills, and interventions will need to focus on directly teaching them skills for resolving conflicts with others. One context in which such interventions may be especially useful is with children who accompany their mothers to battered women's shelters. These children have likely observed interparental violence in the context of conflict, and may have been the recipients of conflict-linked violence as well. Children need not have witnessed or experienced violent family conflicts, however, for them to benefit from opportunities to learn skills for negotiating conflict with peers. Adults who supervise children in any setting can facilitate this learning by negotiating their own adult-child conflicts and by helping children to resolve conflicts with each other. So often in child care settings teachers simply resolve the children's problem themselves ("Give her the scissors") rather than taking the time to have each child state a need and work out a resolution that is acceptable to both.

The proposed interventions are reasonable inferences from the propositions about the learning of conflict-related skills outlined earlier. However, the empirical evidence on which they rest is thin indeed. While it is reasonably certain that children are affected adversely by witnessing violence between their parents (Emery, 1989), it is unclear whether the "effects" are attributable solely to witnessing because observation and direct experiences of aggression frequently occur together in families. Thus, the impact on children we attribute to observing violent conflict may be a joint influence of observation and the direct experience of abuse. Nor do we know whether a parent-child relationship, or any adult-child relationship characterized by respect and negotiation, can mitigate the impact on child behavior of observing violence and coercion between parents. Totally absent from the research literature, moreover, is any consideration of the way observed or experienced conflict in families characterized by negotiation and compromise influence the way children resolve conflicts with peers. It is these questions that require attention if our work with children and families is to be based on sound scientific principles.

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Social Development and Integration: Facilitating the prosocial development of typical and exceptional infants and toddlers in group settings

by

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Traditionally, children who spent their first three years of life at home with families learned about relationships within their family circle. Now, increasing numbers of American toddlers are being cared for in groups, away from their parents for large parts of the day. These include toddlers with disabilities for whom early intervention takes place in community-based settings such as child care centers or socially integrated play groups (Bruder, Deiner & Sachs, 1990; Gilkerson, Hilliard III, Schrag & Shonkoff; 1987; Hanline & Hanson, 1989; Klein & Sheehan, 1987; Newby, 1990; Turnbull & Turnbull).

Consequently, caregivers and early interventionists have an increasingly significant role in supporting the development of social competence in toddlers, both typical and exceptional. Toddlers who come to a group setting with early social skills will need ongoing support from caring adults to reinforce and strengthen those skills. We know that preschoolers with special needs show improved peer-related social competence when in socially integrated settings (Guralnick, 1990), *especially* when teachers promote positive social interactions between typical and exceptional peers (Odom & McEvoy, 1988). Children who come to group care from difficult early relationships may need very special care to even begin to feel comfortable around strange adults and other children and later to enjoy and learn from other children.

This article describes attributes which comprise the foundation of social competence in the toddler: 1) a sense of competence and self-confidence, 2) learning to trust and like others, and 3) the prosocial skills that come from learning "the other side of the relationship." The role of the caregiver in the development of social competence in toddlers with special needs in socially integrated settings is illustrated, and recommended strategies for promoting these attributes of prosocial interactions for all toddlers follow each section.

A sense of competence, mastery, and self-confidence

Jamal was thin and frail when he began attending the child care center. A few weeks earlier his first birthday had been celebrated in the hospital, where he was being treated for "failure to thrive." In Jamal's home, the adults were preoccupied with the effects of terrible losses and personal violence. During his first year no one had time or energy for Jamal. By his second year, he didn't expect any attention.

At the child care center Jamal indiscriminately produced a flat smile and held out his arms for anyone who approached. Sometimes he would wander around carrying a toy in each hand, but giving the impression that he had forgotten they were there.

The caregivers recognized that they would need to help Jamal become aware of himself and his own needs before he would be able to enjoy the other toddlers. Although they were busy, caregivers found special times to feed him alone in addition to the group's snack and meal times. At naptime he was rocked to sleep in loving arms. Often, he sat quietly in the caregivers' laps, comforted by the closeness.

For several months there was little change in him. Then, slowly, from the haven provided by his caregivers, he began to express some of his feelings. He looked happy to arrive at the center.

As Jamal expressed more feelings, he began to act in his own behalf. He chose toys that he wanted and would give his caregivers a fleeting, proud smile while playing. He was interested in new activities. Sometimes he stood near other children, watching them, and smiling at their activity.

Having adults patiently learn about Jamal's feelings and his desires helped him begin to know himself and see himself as being able to make good things happen with other people.

In a young child's first relationships with adults the infant learns, "I am worthy of getting a response. I am someone important." An infant's feelings of self-worth and self-confidence grow each day when he is with a person who cares enough to try to understand what it is the baby is communicating and meet the baby's early needs for comforting and nurture. As infants make things happen, as they behave and get a prompt response, as they learn about cause and effect relationships in their first relationship with a special adult, and as their deep emotional needs are met, they gain a sense of competence and self-confidence. This sense of the infant that "I am important. I can do things. I can communicate. I can make things happen. I can get my needs met" is at the root of all motivation to interact with others. When an infant feels confident that he or she can get a response, then the infant is much more likely to attempt to interact with toys, peers, and adults.

Shareen picks up a toy and throws it at another toddler in her child care center. The teacher reprimands her. Shareen begins to follow the teacher.

At lunch time, Shareen sits, not eating her food. The caregivers discuss how she never eats her lunch and yet she always wants the dessert that follows. One caregiver reaches over the table and takes Shareen's plate and throws it into a large trash can. Shareen angrily gets up, comes around the table, picks up her plate out of the trash can, and throws it on the floor. Another caregiver picks it up and says, "I don't like that, that makes a mess on the floor." The caregiver sits on a chair and with gestures invites Shareen to come sit on her lap. Shareen approaches and begins to hit the caregiver on the legs. The caregiver says firmly but gently, "That hurts, I don't like you to hit,

do you need a hug?" Shareen melts into the caregiver's lap for a hug.

This toddler, observed in a community-based child care center, has a difficult attachment history (Wittmer, 1991). She did not initiate interactions with peers. Rather she remained close to her special caregiver. When peers approached her, she rejected them. While quite ambivalent in her relationships with adults, it seemed as if she had to gain competence and self-confidence with adults before she could enter the world of peers. Luckily for this little girl, one of the caregivers understood and met the deep need that she seemed to have to be close, get hugs, and consistent caring attention from the special adult with whom she was developing a relationship.

Observed in a play group setting, typical toddlers with a good relationship history were seen as "attractive interactive partners" (Jacobson & Wille, 1986). These children received the greatest number of positive responses from their peers as compared to toddlers with insecure attachment histories who were either uninteresting (with avoidant attachments) or disruptive, combative and resistant (with ambivalent attachments). They had greater confidence and effectiveness in dealing with objects and people. They were more interesting, and other children sought them out as playmates.

When infants do not feel that they can master the environment of people and objects, they may give up and avoid people, objects, or both—or interact with them in inappropriate ways. Children who have suffered early abuse, for example, are not well prepared for later relationships. Main and George (1985) observed that abused infants were much less likely than others to approach their caregivers in response to friendly overtures; when they did so they were more likely to approach to the side, to the rear, or by turning about and backstepping. In response to friendly overtures the abused infants more frequently avoided peers and caregivers or combined movements of approach with movements of avoidance.

These children require a reparative relationship with an adult. "It is only when *relationships* are recognized as the major issue that changes in the quality of care can happen that will make the day care of children more appropriate." (Pawl, 1990) It is essential that a child care provider or early interventionist attempt to fulfill the child's early, unmet needs for security by being a sensitive, responsive partner. The child may not easily accept the adult's overtures. The adult must be persistent and unconditionally available, realizing the importance of helping build the toddler's self-confidence in relationships with adult's first and peers later.

How applicable are these observations to young children with disabilities? Are toddlers with disabilities developing a sense of competence and self-confidence in relationships? If they have had a positive relationship with their primary caregivers during the first years of life, do they then have a sense of competence with peers? Are they sought after as interesting partners? We do not yet know the answers to these questions.

The parents of infants with special needs have been found to compensate and work harder at reading often subtle cues, so that they can comfort the infant and interact in positive ways (Minde, Perrotta & Hellman, 1988; Wasserman, 1985). This pattern works with the infant and his special caregiver. However, as the toddler with disabilities moves into the world of peers, she may have difficulty communicating her needs. Moreover, the young child's peers, both typical and exceptional, have fewer skills for compensating for the toddler with special needs than did his special adult. The child will need a sensitive, attuned adult to interpret her desires to interact with other children.

SUBJECTS & PREDICATES

The caregiver also needs to teach other children how to compensate for skills that are lacking or emerging, and how to build on the strengths of the toddler with special needs, so that peers can enjoy each others' company. In a study of an integrated child care setting, only seven percent of the total positive/neutral interactions observed (Wittmer, 1991) involved the toddler with special needs as a recipient of initiations from other toddlers. And approximately half of the incidents of peers comforting, helping, or giving to toddlers with special needs in integrated settings occurred after the teacher requested the typically developing child to do so (Wittmer, 1991). (Interestingly, there was also only one occasion when a toddler with special needs was observed to be the recipient of any type of negative approach from other toddlers.)

Henry, a child with cerebral palsy, is carried by his caregiver to the midst of children playing with miniature balls in a wading pool. Propped in his teacher's lap, Henry watches Alex dive in and out of the hundreds of colorful balls in the pool. Several girls push some of the balls on Henry and he smiles. After Henry watches for another five minutes, the teacher

Strategies for helping children learn self-confidence in relationships and developing children's self esteem:

1. Respond quickly and sensitively to toddlers' expressed needs so they will feel secure and important and gain self-confidence in learning how to communicate their needs.
2. Make sure that each child builds a strong, positive relationship with at least one adult in the room. Infants and toddlers need a secure base to which they can return for comfort, an adult from whom they can learn that they are special.
3. Give particularly attractive toys to the child with disabilities or the child who is having difficulty with peer interactions, sometimes letting that child use a new or seldom offered toy. This will help make the child a more attractive play partner and develop the child's sense of competence.
4. Raise the status of the child with disabilities by your own loving, welcoming attitude. Say, "I love sitting next to Ting-Ting. She gives me big smiles."
5. Use books in the classroom that show children and adults with disabilities in a positive light. Read stories about children with special needs. This will help toddlers with disabilities develop a sense of self-worth and typical toddlers understand disabilities and see the strengths of exceptional toddlers.
6. Use posters in your room which show children with disabilities participating in daily activities with other children.
7. Interpret the sometimes subtle cues of children to other children. "He said, 'Hi.' Say 'hi' back", or "She's really looking at that doll. I think she wants that doll." Another way to interpret is to "talk for" the child with disabilities, saying "Sarah wants to help with those blocks. She says, 'I want to play, too!'"
8. Find some way for the child with disabilities to communicate. If he/she cannot speak, you might try sign language, pictures, or communication boards.
9. Enhance the competencies of children with disabilities by: providing room for strollers, wheelchairs, or walkers between all activity areas; providing toys and activities within reach from a stroller or wheelchair; providing adaptive furniture that allows the child to participate in an activity such as art; adapting toys with switches for a severely physically involved child; adapting toys and materials for easier use, for example, making crayons or markers wider for easier grasping by wrapping masking tape around them; and varying lights, sounds, and textures in order to provide important information for children with sensory impairments.
10. Make a point of seating a child with disabilities close to the most socially competent of his peers, particularly a competent but somewhat younger child.

asks Allison to throw some balls to Henry. She throws a ball in Henry's direction and the teacher then assists Henry in throwing the ball back to his playmate. They take several turns, as Henry smiles.

Henry gave positive feedback to his peers who were playing with him. Other young children with special needs may not. In a population of typical toddler peers, the ability to initiate appropriate prosocial overtures appeared to exceed their ability to respond in a manner to sustain the social interaction (Bronson, 1975). Wittmer (1991) found that several toddlers with special needs avoided, ignored, or cried when other toddlers tried to interact with them. All toddlers, including toddlers with disabilities, need special help in knowing how to respond to another toddler's initiations.

Learning to trust and like others: Wanting to be social

Trevor was the first child with a disability to attend the child care center. Trevor had Down syndrome. At the age of 18 months he crawled, and he didn't use any language.

Because of their own ideas about his disability, Trevor's care providers perceived him as being fragile and in need of protection from everyone and everything in the environment. They kept him away from the other toddlers, strapped him into an infant seat at mealtimes, held him on their laps during play times, and had him napping in an anteroom, so that the other children "didn't bother him".

Trevor was very lonely in child care. He was about to teach the child care providers about the impact being around other children can have on a child. The toddlers in the classroom did interesting things nonstop. They ran from one side of the room to the other, challenging each other with a look to join in or keep up. They copied each other's table banging and screaming, making them louder with each imitation. They carried toys everywhere.

As Trevor watched the other children playing, moving, and singing he became increasingly frustrated by the care providers' failures to move him along with the group. Sometimes he would join in the imitative play from a distance. He began to pounce on any opportunity when he was not physically constrained to crawl, and then walk, to where the other children were. His movements became faster and more purposeful. Trevor's moment-by-moment goal seemed to be to get close to the other children and do what they were doing. This interest in watching and

imitating proved to be a powerful motivating force for him to try activities he'd refused before. Being familiar with sign language made him proficient at finger plays during music time. Trevor's previous interest in letting balls roll away from him and crawling after them gave way to shyly hanging around ball play at the center, and insistently initiating reciprocal ball play at home with his parents.

For Trevor, being able to watch other children provided an opportunity to experience the many ways in which he and they were the same. Being around other children motivated him to try the wide range of activities that could allow him to be part of the group.

In infants' first relationships with adults, they learn to enjoy being with other people. Babies with positive first experiences learn that adults (and people in general) can be caring, loving, and responsive. Thus infants learn to like people. They believe that people (adults and children) are fun and interesting to be with and that they can benefit from being near them.

Toddlers show an interest in other children, as well as adults, and want to be around them. Twenty-two to twenty-four month-olds, compared to ten to twelve-month-olds (Eckerman, Whatley & Kutz, 1975), showed significantly higher frequencies of both interactions with peers and contacts with toys. Watching and distant social contact were more common than physical contact. Children from 10 to 24 months do not appear to treat each other like physical objects. Their social responses toward each other are not like those made toward adults (Eckerman, Whatley & Kutz, 1976).

Imitating another's actions is a core behavioral accomplishment during the toddler period. Watching and imitating are seemingly very important ways that toddlers learn from each other. Their ability and interest in imitating increase as toddlers become older (Eckerman, Davis, & Didow, 1989).

What do we know about imitation among toddlers with disabilities in integrated settings? Wittmer (1991) found that in fourteen hours of observation of seven toddlers, the toddlers with a variety of special needs made 117 initiations to other children. Only six percent of these resulted from a teacher's direction to interact with another child. Twenty-three percent of all positive/neutral behaviors included watching another child, while 23 percent of the behaviors included imitating another toddler. Approximately 70 percent of the total interactions of the observed toddlers with special needs with other children were with typical peers, 24 percent were with a mixed group of typical and exceptional peers, and only six percent were with other special needs toddlers alone. It would seem these children enjoyed being with typical peers. Seventy-nine percent of all interactions (as initiators and recipients of interactions from other children) were positive; these included joining in play, comforting, helping, giving, saying "Look at me," conversing, or showing or offering a toy.

Two children with severe motor impairments, however, did not initiate to other children. Another toddler with language delays also did not initiate interactions on his own.

Kevin wandered around the play room, running first to the chalk board and then over to the swing. A teacher, rocking a boat full of children, called to him. "Kevin, do you want a ride?" Kevin glanced at the boat and ran to the other side of the room. The teacher called again as she rocked the boat, "I need some help. Will you help me rock the boat?" Kevin again ran to the other side of the room and from a safe corner watched the teacher rock the boat for several minutes. The teacher gestured for him to come over. Kevin looked longingly at the teacher and boat and walked slowly to the boat and began to help push. The teacher sang, "Row, row, row your boat."

These children needed a caregiver to take a very active role in helping them "get started." Caregivers may need to guess the meaning of the child's signals, help to manipulate the child's hands to sign or play, and actively engage the child in some form of social contact.

Learning the other side of the relationship: How to be prosocial

This morning nothing in the toddler room interested Amber. She stared ahead blankly while fingering a cracker at the snack table. She didn't seem to notice when the other children cleared their things and moved on to play around the room.

Amber has a syndrome that made her head grow large and heavy for her body to carry. Her nose is small and her tongue so large in her mouth that sometimes simply maintaining her breathing and sitting upright require all of her concentration and energy.

Amber's care provider lifted her from the snack table to a quiet spot on the carpet. "Here's your favorite, Amber," the caregiver said directly into Amber's ear as she showed her a shape sorting box. Amber did not respond. "Would you like a record?" the caregiver tried again, "Or maybe this _____" and the caregiver set a small xylophone in front of Amber. The caregiver moved across the room to talk to another child, maintaining her quiet supportive attitude as she moved from child to child.

James, another toddler, scooted in next to Amber facing the xylophone. James picked up one mallet and began to strike the keys carefully and with great pleasure. 'Wanta play?" he asked Amber, who was sitting very still, except for snuffly breathing. Amber slowly looked at James, who took her gaze as an affirmative response. James picked up the second mallet, used his chubby fingers to pry open her stiff fists, fitted the mallet against her palm and helped her close her fingers around the stick. "Now you can play, Amber", he said, as he began to help her make her own music.

As they interact in their first relationships, young children "learn the other side of the relationship" and then model the sensitive caring or the not-so-loving responses that they have received. They then use those same interactive strategies with both adults and peers.

The child who is responded to by adults in affectionate, kind, empathetic ways is learning how to be a communicative partner who knows how to take turns, listen, empathize and help. Park & Waters (1989) found that when two children who had experienced affirmative first relationships with their mothers played together, the play was more harmonious, less controlling, more responsive, and happier than when children who had not experienced positive first relationships played together. Howes & Farver's (1987) work shows that toddlers in child care, ranging from 16 to 33 months of age, responded prosocially to peers who showed distress. Ninety-three percent of peer responses to children's cries were prosocial in nature.

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Children who have been abused also show that they have learned "the other side of the relationship". In their 1985 study of 10 abused and 10 matched toddlers, ranging in age from one to three years and all from families experiencing stress, Main and George found that toddlers who have been abused will not show concern for a toddler in distress. Rather, the abused toddlers were found to physically attack, show fear, or show anger to the distressed toddler. Three of the abused toddlers alternately attacked and attempted to comfort the crying toddler. This ambivalent approach, alternating between comforting and angry, hurting attacks, probably reflects how the abused toddlers were treated by the important adults in their lives. The nonabused toddlers from stressed families did show concern and sadness, and often attempted to comfort a toddler in distress.

Strategies for building on and encouraging children's desire to watch, imitate and be near others

1. Place infants beside each other on the floor, in supported seats, or facing each other in high chairs. Infants like to watch each other.
2. Provide duplicates of toys to encourage parallel play.
3. Offer toys and activities that promote social interaction rather than isolated play. Some favorites among toddlers are a large bin full of ping-pong balls, water, or sand; coloring or painting on a huge sheet of paper that everyone shares; or musical instruments.
4. Find a way to include children with special needs meaningfully in all activities. They need to participate fully with appropriate goals.
5. Care providers should make an effort to have typically developing peers near the child with disabilities during the day. Sometimes we tend to group all the children who need special help together and they have less opportunity to learn from more competent children. If a child with disabilities is not independently mobile, he should be moved with the rest of the children when they move. If the children move from the snack table to free play, a care provider should help the child with disabilities to move with the others, so that he is not always the last to get to a new activity or the last to get a turn.
6. Build on toddlers' inherent desires to imitate others by focusing the attention of the child with disabilities on the behavior of other children. If other toddlers are patting a table, say "pat-pat-pat" as you show the child how to pat his/her hand on the table. Encourage all of the children to play imitative games with sounds and movements.
7. Toddlers like to play beside each other. A child with special needs may need help joining the other children in settings such as a sand box or a wading pool.
8. It may be necessary to use supports and prompts to help some children stay involved in activities with other children. The strategies used to support the child should be as non-intrusive as possible. If a spoken facilitation such as, "Look what you did. You moved it way over here" does the job, it is much better than your standing behind the child guiding his hands in yours.

In a more specific illustration of what it means to learn the other side of the relationship, typically developing infants learn about the ways their parents compensate for them in infancy as communication partners. We know that children as young as three will simplify their language with younger children, dolls, and animals. Toddlers may

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in turn compensate for the limitations of a child with disabilities as a communication partner (with a little encouragement from adults). When typical toddlers in an integrated setting began an interaction with a toddler with special needs, 88 percent of those behaviors could be considered prosocial (comforting with a pat on the head, saying "sorry", turning on the water in the sink, playing ball, giving a turn). These behaviors did not happen frequently, but approximately 50 percent of the behaviors observed were initiated by the typical toddler herself (Wittmer, 1991).

Haniya a toddler with cerebral palsy, crawled with great difficulty, making her way across the sand to the door of the building. Carl, riding by with great speed on his tricycle, came to an abrupt halt, got off his bicycle and leaned down by Haniya. He patted her head gently, and then hopped on his bike and rode off.

Although this action on the part of Carl may seem condescending to some, it demonstrated that Carl seemed to want to comfort Haniya, and did so in the best way he knew how. Patting Haniya on the head had no benefit for himself and thus seems truly a prosocial act.

Caregivers, however, also play a very important role in helping young toddlers learn how to be helpful, caring, and kind.

The caregiver positioned Haniya on the countertop, so that Haniya could hold her hands under the faucet. Jonathan appeared out of nowhere to wash his hands before snack. The caregiver said to Jonathan, "Please turn on the faucet for Haniya." Jonathan did. Haniya glanced at him and gave a faint smile. She stuck her hands under the faucet of running water, seeming to enjoy the cool feeling on her hands. Jonathan stuck his hands under the water also and then quickly ran off again. Haniya peered at the place where Jonathan had gone.

Are toddlers with special needs learning the other side of the relationship and behaving in prosocial ways? Four of the seven toddlers observed did not comfort others (Wittmer, 1991). However they did help (2% of positive initiations), they gave objects (7%), showed objects (3%), showed affection (1%), smiled at a peer (13%), and touched gently (3%). They also did a great deal of watching and imitating and "Imitation is the sincerest form of flattery". Only 12 percent of the prosocial actions of the toddlers with special needs were teacher-directed. The few hurtful behaviors of these children involved slapping, yelling at, and scolding other children.

There is evidence that children are capable of initiating positive acts and behaving more prosocially as they mature. Holmberg (1980) found that the frequency of both initial positive acts and " elaborated interchange patterns" increased with age across 12 month to 42 month-old children. Eckerman, Whatley and Kutz (1975), found that toddlers' positive interactions outnumbered negative ones, and positive interactions increased at a faster rate than negative ones.

Strategies for helping children become more prosocial

1. Respond quickly and sensitively to babies' needs so they will feel secure and learn how to treat others gently and kindly.
2. Model treating all children in the ways you want them to treat others. Your example of kindness and appreciation will influence the tone of the interaction among the toddlers in your room.
3. Help toddlers learn cause and effect in social relationships. Teach them how their behaviors affect others. Say "You smiled—that made her happy" or "You hit him—that hurt him" (said with feeling).
4. Offer toys that promote cooperation, such as a heavy wagon with a handle large enough for two children to pull together.
5. Coach peers through approaching the child with disabilities. "Here, Juan, you can ask Michael if he wants this puzzle or that one. Good. Carry them to Michael. Hold them where he can look at them. Ask him 'Which one, Michael?'," etc.
6. Point out every child's prosocial behaviors with admiration to the other children.
7. Encourage problem solving and understanding by using dolls with special needs. Say, "This doll can't see. How can we help her eat?"
8. During free play times, subtly arrange small groups of two to three children to increase cooperative play.
9. Encourage children to help each other. Say, "His nose is running. Get a tissue please," or "Turn on the faucet for Kayla, please."
10. Acknowledge the differences between children, but stress the likenesses among them. "Taylor uses his hands to talk, instead of his mouth. But he wants another cookie just like you!" or "Jane's hands have trouble holding the chalk, but she likes all the pretty colors on her picture, too."
11. It may be necessary to teach a child with severe disabilities how to perform such basic social skills as smiling. This may be done by rewarding the skill (i.e., smiling) when it appears spontaneously or by direct instruction.

Toddlers demonstrate the first steps of social competence through their prosocial behaviors in group settings. Caregivers as well as parents help young toddlers develop the foundations of social competence by helping them (1) gain a sense of competency and self-confidence, (2) learn to like and enjoy others, and (3) learn how to be prosocial through experiencing the positive aspects of "the other side of the relationship".

ROBERT MAUST

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CHILDSPACE—Creating An Environment of Respect for Infants and Toddlers and Caregivers of Children

by

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It's conventional wisdom. We all know children learn from their experience. Yet, when it comes to "moral" behavior or the development of social and spiritual consciousness, organized religions have traditionally seemed to believe that children are unable to learn these concepts until after the age of three. Many parents seem similarly convinced that children must be "taught" to share, be kind, be generous, etc.

Curriculum development

The coauthors of the Childspace philosophy set out to create an experiential base from which children could develop respectful social behaviors and authentic selfhood. **CHILDSPACE** is based on the principles of respect for infants found in work of infant specialist Magda Gerber. The coauthors of **CHILDSPACE** shared responsibility for and a commitment to providing a respectful environment for infants and toddlers in the Religious Growth and Learning programs of their local Unitarian Universalist churches. Previously, as in most denominations, there was no curriculum used in Unitarian Universalist churches for this age group. Newborn to three-year-old children were simply provided babysitting for the hour during which their parents attended the service, and the older children attended church school.

Unitarian Universalists have no set dogma or doctrine in which members must share belief but do have principles and purposes adopted at their general assembly. Several of these principles and purposes seemed clearly congruent with Gerber's principles of respect. The coauthors sought to translate those Unitarian Universalist principles to an environment of learning for the infant and toddler age group. The relevant principles and purposes include: the inherent worth and dignity of every person; justice, equity, and compassion in human relations; and a free and responsible search for truth and meaning. We felt that by making these ideas applicable to children of all ages, starting with newborns, we would help children form a base experience from which to understand, interpret, and assimilate all the religious education concepts we present to them later in more verbal and rational forms.

We set about creating a model for a one-hour Religious Growth and Learning experience for infants and toddlers that embraces Gerber's attitude of respect and the above-mentioned Unitarian Universalist principles. But how would this be different from the usual "babysitting"? Gerber recommends respecting infants by providing an environment that is "physically safe, cognitively challenging, and emotionally nurturing". In our original model, we described how to set up the physical space and what play objects were appropriate to have available. We provided scenarios to demonstrate that embodying respect for infants and toddlers is about "being" there for them while the infants and toddlers are initiating the "doing". We soon realized that the most crucial variable in creating a respectful environment for children of any age is the caregiver. For this reason, we shifted our focus to how to enable the caregivers to embody the principles illustrated in our scenarios.

We noticed a gap between what caregivers know about children and what they actually do with them. As we each begin the challenge of taking care of young children for extended periods of time, our childhood experiences may come to the forefront of our immediate responses. Often, other stresses in our lives, such as time demands or adult arelationship conflicts, affect how we deal with children. We all have intellectual ideas of how we think we "ought" to interact with children. However, the first responses that come out of our mouths or through our body language under stress may be strikingly similar to the handling we ourselves experienced as infants and young chidlren rather than what we have learned from parenting books and classes. This dissonance often results in caregivers feeling guilty or inadequate. These feelings may emerge as anger directed at the children.

CHILDSPACE CAREGIVERS

We decided that providing an environment of respect for caregivers' development would give caregivers not just an intellectual base but an experiential base for providing that same respectful framework for children. We created a group curriculum for caregivers that would give them a way to evolve respectful caregiving skills from their own experience. We called the group curriculum **CHILDSPACE CAREGIVERS: A Curriculum for Those Who Care for Children of Any Age.** Although we believe that people learn respect for themselves and others best when their experiences from birth embody them, we also believe that an experiential base can be provided at any age. Through facilitating group problem solving among parents and caregivers of children of any age, we respect parenting and caregiving as a developmental process just as we respect the developmental process we observe in our children.

We are in an age of heightened awareness of dysfunctional family patterns, codependent relationships, and child abuse. We wanted to create new possibilities for healthier relationship patterns so we can, in our generation, begin to break these multigenerational cycles. In coauthoring **CHILDSPACE** we hoped to help caregivers explore new relationship patterns that will be helpful to them, their children, and others around them. We chose to do this through providing reflective learning experiences focused on daily relationships with children. In creating **CHILDSPACE**, we respected the fact that parents and

CHILDSPACE					
Childspace Caregivers: A Curriculum For Those Who Care For Children Of Any Age			**Childspace Infants and Toddlers: A Model And Workbook For Their Caregivers**		
Introduction and Facilitators Guidelines			Introduction		
			Childspace Guidelines		
LESSON PLANS	Structure	Content	Structure		LESSON PLANS
	Preparation	**Watching the Wheels Turn** (Respecting child-initiated activities and problem solving.)	Self-Exploration Questions		
	Introduction	**Just One More Kiss** (Exploring issues of separation.)			
	Current Topic Conversation	**What Goes Up Must Come Down** (Respecting each child's developmental pace.)	Suggested Readings		
		"Some Like It Hot ..." (Validating children's sensory experiences.)			
	Chapter Review and Discussion	**"There's Nothing To Be Afraid Of."** (Dealing honestly with emotions.)	Topic Summaries		
	Implications in Action	**Hand In Hand** (Transforming necessary care into quality time through cooperation.)			
		Where To Draw The Line (Trusting your intuition in defining limits.)	Scenarios		
	Looking Ahead to the Next Topic	**The Urge To Kill** (Dealing with issues of anger in ourselves and our children.)			
		Eating Your Words (Developing clarity and honesty in language.)	Integration and Action		
	Topic Summaries	**"You're Not My Friend Anymore."** (Exploring issues of sharing and social relationships.)			
Appendix			Appendix		
Curriculum Information	Resource Materials	Participant Forms	Parent Information	Resource Materials	Caregiver Forms

Figure 1

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caregivers, like children, learn best through their own problem-solving experiences.

In deciding on the focus for the group sessions, we looked for issues that are hot emotional triggers both for children and for their caregivers. These choices came from our own experiences as parents and caregivers. The titles, designed to strike a familiar chord with parents and caregivers, are listed on the overview chart of **CHILDSPACE** in figure 1.

For each issue session, we provide a centerpiece image to focus the attention of the participants on the issue. To stimulate discussion, we invented reflective questions through which the caregivers could use their personal experiences as problem-solving material. We carefully sequence the questions through a progression from ones that ask participants to share simple, objective data to ones that elicit feelings and judgments. We use readings from the book *1, 2, 3 ... The Toddler Years* to supplement the examples from personal experience raised by the participants. We close sessions by having participants look at specific ways they could use insights they gain from the discussion. After each group meeting, we hand out a topic summary we wrote for that issue with examples that embody the respectful approach we are advocating. By using participants' experiences as the content of the sessions, we respect their learning through their own problem solving and help them build new experiences from which to learn.

The group curriculum is designed to provide an environment of respect for discussing parenting issues. This provides parents and caregivers with an experiential base for the kind of respectful interactions we are asking them to consider with their children. The group raises consciousness about respecting our children and enables parents and caregivers to provide support for each other. While the group does share solutions that the participants themselves have discovered, it does not do specific one-on-one work with individual parents or caregivers. **CHILDSPACE** raises the participants' awareness of their own issues. They may want to seek individualized help if they are stuck in unhelpful relationship patterns.

CHILDSPACE INFANTS AND TODDLERS

While we were working on the group curriculum, we were still struggling with how to effectively implement the model for our infant and toddler class. We initially focused on physical caregiving because these are the primary interactions with children. We were interested in how consciously respecting infants and toddlers would affect the way in which caregivers fulfilled the children's needs. However, because caregivers tend to focus more on the *needs* of young children than on their competencies, we also looked beyond the children's basic needs to what they are *learning* at this stage of life. Infants and toddlers spend their time discovering themselves and their environment. They are finding out how the world works and how they, as physical beings, relate to it. We believe respecting infants and toddlers is, in part, about how to avoid interfering with their self-initiated exploring, discovering, and learning. We needed a mechanism for training volunteer caregivers that respected their evolution as caregivers even if they did not choose to attend the group curriculum. We also needed to shift the image caregivers have of a curriculum model for children. Caregiver volunteers wanted to know what to "do" with the infants and toddlers under their care. Caregivers were expecting a "curriculum" of structured activities like those provided in classes for older children. Our model, on the other hand, was more about "being" than "doing."

We created **CHILDSPACE INFANTS AND TODDLERS: A Model and Workbook For Their Caregivers.** In deciding on the focus of our attention, we again looked for issues that are hot emotional triggers both for very young children and for their caregivers. In order to focus the workbook sessions, we emphasized the same ten topics we came up with for the group curriculum. For each issue session in the workbook, we adapted the reflective questions from the group curriculum to a form through which the caregivers could independently use their personal experience as problem-solving material. We expanded the scenarios we had previously written to provide descriptions of realistic interactions between children and between children and caregivers to model the language and behavior of respectful interactions. We included the topic summaries for each issue from **CHILDSPACE CAREGIVERS** that embodied the respectful approach we are advocating with a narrowed focus on the infant-toddler age range. We created additional reflective questions to engage the caregivers in making judgments and decisions of their own about the concepts illustrated in the session.

For our Religious Growth and Learning programs, caregivers who volunteer to supervise the infant and toddler classes are each given a workbook to complete at their own pace. We encourage the caregivers to come and do a workbook session fifteen minutes before they need to set up the class. This time provides a pause for the caregiver to refocus on the perspective and issues of infants and toddlers before the class begins.

The workbook encourages caregivers to bring self-consciousness to the ways in which they relate to children. It guides them through a discovery process for noticing what they already do that works for them and their children and offers alternatives for them to consider in areas where they feel less successful. By using the workbook in conjunction with volunteering in the classroom, caregivers have an opportunity to practice new alternatives they choose to use. Caregivers often find it easier to notice their relationship patterns when they are relating to other people's children than in either the emotional intensity or habitual patterns of relating to their own child.

Each of the ten sessions is designed to help parents and caregivers find ways to support infants and toddlers in their growing self-awareness. Each session is intended to encourage caregivers to get in touch with their own experiences and, through this process, to develop confidence in their ability to relate to and care for young children. We believe that caregivers who feel competent and respected can, in turn, provide experiences for the children which build confidence, nurture self-esteem, and encourage autonomy. The children, then, are developing a base of experience from which to relate to themselves and others throughout their lives. Each session approaches these basic values and how to provide these experiences through a different practical issue.

Topic sessions

In **Watching the Wheels Turn,** we ask caregivers to explore what respect means to them. Then we help them apply their insights to young children. While infants and toddlers need adults to fulfill many of their needs, there are also many things they can do on their own. Adults often feel they must entertain babies or they will be bored. What does this teach our children? It is important for us to respond to our infants. It is important that they learn they can trust us and that their needs will be met. However, it is also important that they experience their own growing competence in living in the world and meeting their own needs. Very young infants are just discovering everything. Everything is new and interesting and, at times, overwhelming. What their bodies are like, where they are in space, and how to calm themselves when they are tired or overstimulated are all things infants need to learn for themselves. Trusting them to learn and respecting their pace, watching and waiting a bit before assuming they need our help, gives infants the experiential base for self-esteem and confidence. With a very young infant, placing her on her back on the floor with visually interesting objects to the side allows her to initiate her own interaction with her surroundings. Speaking to the infant about what she is doing lets her know we're available and validates her current competencies. "You're kicking your legs hard. Yes, you see the striped scarf. You're touching it with your fingers."

By helping caregivers explore their own attitudes and ideas about infants, we hope they become more

comfortable and confident around infants. There can be no rules for when to help or hold an infant and when to wait. Each child comes into the world as a unique being. Each child's personality, emotional demands, and ways of communicating will be different. If caregivers feel confident, they can attend more to the child and less to their own distress. They can observe and learn their child's unique patterns.

As infants grow into toddlers, they do a lot of exploring. They discover cause and effect. They build a base of concrete experience of the world. While this is a time when children depend on us and want to feel cared for, it is also a time when they are developing their independence from us and want to feel powerful. We can respect their self-initiated activities by attending without interfering. When a child is spinning the wheels of a truck, he may not be interested in the fact that trucks can roll along the floor. A child chasing, picking up, and dropping a ball to chase it again may not have the motor skills or interest yet in throwing the ball. A child develops his sense of competence from doing the things he *can* do. We treat what the child chooses to do as important when we avoid asking him to change what he's doing to something we think is better (more fun, developmentally further along, more correct). Then he learns from his experience that what *he* does is important. "You're making the wheel turn. You're watching it go around."

In **Just One More Kiss,** we explore issues of separation. The development of trust, the fear of abandonment, the need for attachment, the desire for independence are areas in which we develop our whole lives. A foundation for our relations to others throughout our lives is laid in the handling of separation issues when we are infants and toddlers. Because these issues are so basic, parents and caregivers are often as emotionally caught up in the process of separation as are their infants and toddlers.

Some parents feel bad if their child cries at separation. They may be embarrassed by the child's behavior. Some parents feel bad if their child doesn't cry (and may prolong the process of saying good-bye until the child does). They may worry that their child doesn't love them or miss them. Some parents feel guilty leaving their child. They may feel this way whether their child cries or not. Some caregivers feel bad if a child doesn't stop crying as soon as his parents are gone. These feelings are often put on the children. "Please stop crying. Mommy loves you. I *have* to go to work." "Please don't cry. It will make me feel bad if you cry. Don't you like me?" Having parents and caregivers explore their own needs and feelings about separation helps them recognize which needs and feelings are their own and which really belong to their child. It helps them recognize that crying at separation from parents demonstrates a new level of thinking in an infant and is a sign of healthy growth. It allows them to focus on the child in the situation.

We can empower a child in this developmental process by acknowledging his feelings. It is often hard for adults to see small children experiencing "negative" emotions. However, allowing those emotions validates the child's experience. We undermine a child's experience of himself if we say, "It's not *that* bad." or "Don't cry. They'll be back soon." Denying the emotion may cause a child to escalate his reaction, in effect, saying, "It is, too, that bad!" Or he may simply repeat what he is doing in an attempt to be heard. Acknowledging the sadness, fear, or anger, often helps the child to process the emotion and move into playing. "You're really upset that Mommy left. I'll stay here with you until you're ready to play." Respecting the child means respecting his reality.

We can further empower the child dealing with separation by expressing our confidence in her ability to cope with the situation. Making sure parents say good-bye to the child, even if the child is happily playing, builds trust. The child doesn't have to worry that, if she gets involved in something, she will look up to discover she's been left. She can trust her parents to tell her when they are leaving. Saying good-bye also expresses the parents' trust in the child. They are not trying to trick her into staying. Their words and behavior say, "We're leaving now and we trust that you can handle it."

Through these experiences the child learns that it is alright to have feelings. He learns to trust both others and himself in the midst of those feelings. He learns that his experience is real and acceptable, that it counts. From this experience of having his own feelings and reality validated, he has a basis for respecting other people's feelings and reality even if they are different from his own.

In **What Goes Up Must Come Down,** we encourage caregivers to explore their images of child development. There are many books available explaining child development stages and describing what children should be doing when. There are books on how to help our children reach certain stages earlier. There are books on the negative effects of pushing our children. Our parents often tell us how we ought to raise our children and other parents tell us what their children can already do. We have our own inner images of what our children should be doing to verify for us that we are good parents. In the midst of all this information and pressure, what does it mean to respect our children? It helps to remember that we provide the environment: our children do the growing.

We are responsible for the health and safety of our children. Infants and toddlers are discovering their bodies and what they can do. They are learning to deal with gravity and other factors in the environment. We can help them be safe by childproofing the environment in which they play. We also help them be safe by respecting their pace of physical development. If we allow them to become expert at each stage of development without pushing them to move on to the next stage, they develop their own physical competence. Sitting a child up when he cannot get down from that position inhibits his exploration of the movements and

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balance required to move from lying to sitting. To move from lying to sitting, lying to crawling, sitting to standing, crawling to walking, all require complex coordination of movement and balance. Infant seats, bouncers, walkers, and swings limit an infant's ability to freely explore how her body moves from one position to another. The learning process involves trying out new movements and then going back to familiar and well developed movements. We help our children be safe by allowing this back and forth pattern of development.

Not only does respecting the child's developmental pace help the child know her own body and be safe within it, but it also encourages the child's sense of self. Infants' and toddlers' sense of self is very connected to their bodies. Infants' and toddlers' sense of competence is very connected to what they are learning to do with their bodies. If they sense that nothing they are doing is enough; that only when they start crawling, Mommy will play with them; only when they start walking, Daddy will pay attention; then their sense of self is undermined. Focusing on what the child *is* doing helps the child sense her own competence.

In **"Some Like It Hot ...,"** caregivers explore sensory perceptions, especially the differences between their own and their child's perceptions. Again, by focusing on respect, we hope to bring to the caregivers' awareness the validity of the child's perceptions. Often adults think they know best. They have more experience than the child has. However, in an argument about sensory perceptions (Is it warm outside or cold?), a child's current experience is just as real as an adult's current experience. "The water feels warm to me but I'll cool it down if it feels hot to you." A caregiver can validate a child's experience while still using wisdom gained from past experience. "I want you to take your jacket with you in case you get cold." A parent can validate a child's experience while still asking for a change in behavior. "I know the T.V. sounds fine to you but I want you to turn it down because it is too loud for me."

In **"There's Nothing To Be Afraid Of,"** we look at dealing honestly with emotions. Many adults these days are trying to find ways to deal with emotions they have repressed for years. Evidence indicates that some diseases are caused by repressed emotions. There is a proliferation

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of books on the topic of handling our emotions. In the midst of this growing awareness of feelings, how do we help our children grow up with the capacity to deal with emotions as they happen? By dealing with our own emotions, now, as adults, we model that behavior for our children.

Children are very sensitive to the feelings of those around them. Parents and caregivers can help children feel more secure by honestly admitting their own feelings. For young children statements about feelings need to be simple and direct. They do not need to know all the complexities of adult emotions. However, particularly if the emotions feel negative, they need to have the feelings acknowledged and reassurance that the adult is taking care of things.

Children's feelings are often very intense. Sometimes all a child needs is an acknowledgement of her feelings. "You sound like you got really scared when that chair fell." Sometimes she needs help finding an appropriate way to express her feelings. Minimizing a child's feelings or trying to distract her may give the message that feelings are too scary or too difficult to handle. When a parent or caregiver suggests alternative ways to respond, it may help a child both to handle the immediate feeling and to sense the adult's confidence in the child's ability to handle her emotions. "You could cuddle your bear or climb up in my lap for a few minutes until you feel better."

In **Hand in Hand,** we ask caregivers to explore their relationship to daily caregiving tasks. Again, we emphasize the child's pace. We encourage parents to find ways to slow down and be with the child during these activities. When so much time with infants and toddlers is spent in practical care, this is prime time for respectful interactions. By doing practical tasks *with* a child instead of *to* the child, caregivers can lay the foundation for cooperation throughout the child's life. Affirming the child's help "You're putting your arm in this sleeve," and offering the child choices, "Do you want the yellow shirt or the red shirt?," empower the child in a situation where he is still dependent on others. Interactive caregiving offers the child a chance to participate and cooperate in a process that is important to him. By relating to the child instead of to the dirty diaper at changing time, parents provide the child with a model for building relationships with others. Children learn to see others as people instead of as "problems" or needs with, by the way, somebody attached.

In **Where To Draw The Line,** we have caregivers take a look at their attitudes and ideas about setting limits. While we encourage parents and caregivers to allow children to self-initiate activities, to give children choices, and to avoid interrupting their children, it is important that these opportunities be offered within a structure. Children need limits. Limits provide a sense of security and help children learn to predict what will happen. Some limits have to do with safety. Often these are the easiest limits for parents to set. "No! You may not run in the street. I want you to hold my hand." "No! Danger! I want you to come away from the plug."

Other limits have more to do with relating to people. Some of these still are safety related: "No hitting. I want you to touch gently." The limits that seem harder to set have to do with preferences. We encourage caregivers to set limits consistent with their own wants and needs. Children can sense this consistency (or the lack of it). A caregiver's internal consistency also makes the limits easier to stick to when a two-year-old in search of independence starts pushing. Different adults feel differently about how children should use furniture, when they should pick up their toys, and so on. Children can understand different rules for different situations. What they can do at home is different from what they can do at Grandma's. The child gains experience of the fact that different people have different wants and needs and he learns to respect these differences.

In **The Urge To Kill,** we ask caregivers to look at issues of anger and to explore both their own anger and their responses to children's anger. Both self-destructive and anti-social behavior are often expressions of anger, either repressed or expressed in violent ways. It is important that parents and caregivers model for their children ways to deal with their anger constructively. By acknowledging the child's anger, even if it is necessary to redirect her behavior, a parent is letting the child know that it's okay to be who she is. By helping a child focus on what she wants in the situation, a caregiver can encourage her to use the energy of her anger to get what she wants. "You're really angry. Joey took your truck and you want it back."

If their caregivers acknowledge and take responsibility for their own anger, the children will copy that behavior. Saying "It's okay" when it isn't presents conflicting words and body language which may confuse or frighten the child. Saying, "It's your fault we're late" or "I spanked you because you made me angry," blames the child or gives him responsibility for the caregiver's feelings. I-statements can clearly state caregiver's feelings without blaming or confusing the child. "When you tear the book, I feel angry." This acknowledges the real situation, torn book/anger, and identifies the anger as the caregiver's responsibility.

In **Eating Your Words,** we help caregivers explore how they use language with children. Today, some parents are aware that children are bombarded with negative phrases. Many are trying hard to make more positive statements to their children. In order to state requests in a positive way, caregivers must become clearer about what they do want. "I want you to play quietly while I visit with my friend." This, in turn, models for children that they can ask for what *they* want and that wanting things and getting what they want are acceptable behaviors.

Infants and toddlers are just learning language. They are literal and concrete in their use of it. To a toddler standing on a table, the statement "We don't stand on tables" is just not true. Saying, "I want you to climb down" clearly states what the caregiver wants in the situation. Infants and toddlers pick up the gestures, style, and tone of the speaker along with the words. Saying what is really happening and what the caregiver really means provides a secure base for developing communications skills.

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Because infants and toddlers are just learning the language, they take labels as telling what a thing is. If a parent applies a label to the child, the child will understand that to be telling her what she is. Saying, "You're a bad girl for spilling your milk. You're clumsy" labels the child. She then acts that way because that is who she is, just like the chair is a chair. Saying, "You spilled your milk. Here's a sponge" allows the child to notice what happened without attaching the label to herself. The way parents use language plays a role in the formation of their child's self-image.

Also, imbedded in the way caregivers use language is their attitude toward the child. A child's attitude toward himself is affected by whether he is talked to or about, whether he is listened to or ignored or interrupted when he speaks, whether he is bombarded by demands or asked to help, and whether he is talked to as a growing independent self or as a thing that won't be a self until he's much bigger. As caregivers stop and listen to what they are saying from the perspective of children, they can find new ways to express the growing respect they have for the infants and toddlers in their care. And as caregivers express their respect more clearly, infants and toddlers, in turn, will experience that respect and be able to relate to others with that same respectful attitude.

In **"You're Not My Friend Anymore,"** we raise with caregivers the issue of sharing and deal directly with social relationships. Infants begin by sensing only themselves and everything else as a part of themselves. They gradually distinguish between themselves and others. Infants begin by simply exploring others the same way they explore things: poke, prod, taste. They progress from "others to exist to serve me" to "others have needs and wants of their own."

As infants get a little older, how they share often becomes an important issue to their parents. Many caregivers feel they have to *make* their children share. They feel that sharing doesn't come naturally and if children aren't forced to share, they will grow up to be incredibly rude. What can we do in the infant and toddler years to lay a foundation for sharing? One element we have already mentioned above is learning cooperation through participating in caregiving tasks. This gives the children experiences of working together with another person and of responding to another in a personal interaction. The children learn to see others as allies rather than as enemies. They learn that being with others and solving problems together can be an enjoyable experience.

Another element may be in the language caregivers use in situations where they perceive sharing to be the issue. Telling a child to share often causes the child to hold onto the toy more tightly. To an adult it seems an easy request to ask a child to share a toy, but how many adults would loan someone their new sweater or hand over their car keys at a moment's notice? Instead of making a demand to share, describing the situation as it is happening is a way that caregivers can help children find their own solutions. "You both are holding onto the truck." "Sarah, Joey's waiting for a turn on the swing." This means being there for the children, helping them see what is happening, limiting the solutions they can choose to ones that are safe for all concerned, helping them find alternatives if they can't see them for themselves, and letting them choose their own solutions without requiring that their choices match what the caregiver's would have been in the situation. This approach takes the caregiver our of the role of enforcer, mediator, or rescuer. It allows the children a safe space within which to experiment with social alternatives.

As children make choices and experience what happens as a result, they internalize the process of relating. Their choices of holding onto a toy or giving up a toy, of grabbing a toy from someone or finding something else to play with, of finding a way to play together with the same toy, all come from their own power and add to their options of behavior. When children's feelings are validated in the midst of this process of relating to others, they discover that they are respected and their needs are met. Then, they become more willing to take turns, to share, and to allow others to use something they have. The

children also build confidence in their own problem-solving abilities. They discover for themselves the rewards inherent in relating to others.

Infants and toddlers will develop relationship patterns largely based on the patterns they experience and observe with their parents and caregivers. If the parent continually steps in to determine who had the toy first, who had the toy long enough, and who did what to whom in order to get the toy, then the child will learn to expect that these situations require someone else to get him what he wants. If the child is encouraged and supported in solving relationship problems for himself, then he will be empowered to continue to do so as he grows older.

Summary

CHILDSPACE INFANTS AND TODDLERS and **CHILDSPACE CAREGIVERS** have been fieldtested at four sites. All of these locations are Unitarian Universalist Churches but they vary widely in size of congregation, number of children and caregivers involved, and training background of the caregivers. The two sites in the Phoenix metropolitan area have been using **CHILDSPACE** for two years through its evolutionary stages. The other two sites, which are in Ohio, have fieldtested the 1991 draft since August 1991. Additional locations have screened **CHILDSPACE** for possible use at their sites and provided us valuable feedback.

The feedback has been very positive. Religious Education directors have articulated the need for more focused attention on the needs of the newborn to three-year-old population. Those who have reviewed it confirm that **CHILDSPACE** fills that need. "The **CHILDSPACE** programs are true religious education at the youngest level. They honor children's natural growth patterns, encouraging but not pressuring, and provide invaluable aid to those at home and at church who carry this responsibility." (Dr. Margaret K. Gooding, retired Minister of Religious Education and author of several children's curricula.) "It's wonderful! ... Precisely the type of material we've been waiting for ..." (Rev. Peggy Clason, UU Society of Cleveland, Fieldtest site for **CHILDSPACE**).

Although **CHILDSPACE** was developed in the context of a Unitarian Universalist infant and toddler class, we believe it has much broader applications. The environment of respect we provide in the one-hour session for infants and toddlers is fully applicable to caregiving settings of much longer duration. The self-exploration workbook and the group curriculum can be easily adapted for parents, teachers, and caregivers of children of any age to explore how their own issues and attitudes effect their interactions with the children in their care.

While both **CHILDSPACE INFANTS AND TODDLERS** and **CHILDSPACE CAREGIVERS** provide images and alternatives for what to do in particular situations with children, the primary focus of both is the attitude of respect underlying any alternative

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actions. The Childspace philosophy is not a cookbook approach. Relationships are built on a multitude of factors. What action to take in a given situation is a varied as the people taking action. Each child, parent, and caregiver is a unique, unrepeatable being. Each is worthy of respect. We hope that **CHILDSPACE** will help to nurture the confidence and self-respect caregivers need to provide an environment of respect for their children. We hope that **CHILDSPACE** will help to nurture the confidence and self-respect children need to create respectful relationships with others around them.

For more information or to order **CHILDSPACE INFANTS AND TODDLERS: A Model And Workbook For Their Caregivers** *and* **CHILDSPACE CAREGIVERS: A Curriculum For Those Who Care For Children Of Any Age,** *contact Carla Oswald Reed, 4739 North 40th Street, Phoenix, AZ 85018, (602) 957-8736.*

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National Center Notes

by Eleanor S. Szanton

The subject of these notes is **hope.** Hope does not get discussed much by social scientists or practitioners. Professionals are much more comfortable with words such as "etiology," "observable behavior," "probability" and "expectable outcomes." This is not surprising. One way of looking at the history of science is to note its slow progression toward reliance on what can be "empirically" detected over and above what one thought one *should* see or *wanted to* see. The "etiology" of a particular set of problems is exhaustively recorded and analyzed by a clinician. Present observable behavior will be checked and tested from many angles. Even the future is clothed in terms of the "prognosis," based on past experience with similar cases.

Parents have a very different perspective—one which is not consulted frequently enough. This was particularly striking to me once when I attended a meeting of 15 or 20 parents of infants and toddlers with disabling conditions. By way of introduction, each parent described her child's condition, when this had become known, what had been the history of her experience with this condition. The cumulative impact of the fifteen stories, each told as if the mother were reading from her child's medical chart, was almost overwhelming. Luckily, at some point in the introductions, each mother began to circulate a snapshot of her child, which she had been asked to bring. The cumulative impact of the photos went entirely the other way. This was a bunch of buoyant, **hopeful** children! For those children, the reality of that hope—those expectations transmitted in some miraculous way from generation to generation—was every bit as strong as the reality of the medical charts.

We have been thinking of the word, **hope,** a lot recently, because it happened to be used both at the opening and at the closing plenary sessions of NCCIP's National Training Institute, held in December, 1991. In fact, each time the word was used by a parent. In the opening plenary, "Early Intervention in the Nineties: A Progress Report and an Action Agenda," Betsy Anderson, the mother of a child with special needs who has used early intervention and special education for over a decade, closed her address by saying to an audience of early intervention specialists, "You have given us **hope.**"

At the closing plenary session, "The Impact of Community Violence on Infants and Toddlers, Their Parents, and Practitioners," Clementine Barfield spoke. Ms. Barfield, a resident of Detroit, saw one of her teenage sons killed and the other severely wounded. She went on to found Save Our Sons and Daughters (SOSAD), an organization attempting to stem community violence. Ms. Barfield said near the end of her talk, "These children have no future; they have no **hope.**"

In an era in which it is fashionable to support the family, preserve the family, hold up the family as an institution which would have to be reinvented if it did not exist, this miracle of **hope,** of focus on "when you grow up" is not at all well understood. However, it must be nurtured and cultivated by those who work with parents and young children. When we allow so many families to sink into situations in which hope fails for parents and children alike, we have destroyed a piece of our hopes for America.

* * * * *

We are very pleased to welcome onto NCCIP's Board of Directors three new members, and another back from leave of absence.

It is fitting to start with **Ann Turnbull, Ph.D.,** Co-director of the Beach Center on Families and Disability at the University of Kansas. Dr. Turnbull, returning to NCCIP's Board from a leave of absence, has done as much as anyone today to communicate the insights of parents to practitioners.

Sheila Kamerman, Ph.D. is Professor of Social Policy and Planning at Columbia University's School of Social Work. She is Co-Director of its Cross-National Studies Research Program. Dr. Kamerman has a distinguished record of comparative research in child and family policy. Author of over fifteen books and many articles with her longtime collaborator, Alfred Kahn, Dr. Kamerman has recently written *Child Care, Parental Leave, and the Under Three's: Policy Innovation in Europe.*

Gloria Johnson-Powell, M.D. is a Professor of Psychiatry at Harvard Medical School and Director of the Camille Cosby Ambulatory Care Center at the Judge Baker Center in Boston. Dr. Powell has held faculty positions at the Center for Health Sciences at UCLA and the University of Minnesota's Institute for Child Development. She has a longstanding clinical and research interest in the growth and development of minority children; and she is editor of the book, *The Psychosocial Development of Minority Children.*

Barry Zuckerman, M.D. is a Professor of Pediatrics at Boston University School of Medicine and Director of the Division of Behavioral and Developmental Pediatrics at Boston City Hospital. He has a distinguished record of research and clinical work with drug- and alcohol-exposed mothers and babies and with depressed mothers. He is a Fellow of the Academy of Pediatrics and a specialist in behavioral pediatrics. He recently served on the National Commission on Children.

We welcome these individuals into positions of leadership, knowing that each has much to say about policies and practices which can help restore hope to families who have none.

Publications:

The Caring Child (1992) - Nancy Eisenberg (Harvard University Press, 79 Garden Street, Cambridge, MA 02138) $22.95, cloth; $8.95, paper.

Part of the Harvard University Press's *Developing Child* series, this book surveys what is known about the emergence of prosocial behaviors (defined as voluntary behavior intended to benefit another) early in life, factors that affect the development of prosocial behavior, and individual differences in behavior such as helping, sharing, and comforting. Reviewing more than two decades of empirical study of prosocial development, the author discusses motives for prosocial actions, characteristics of prosocial children, the biological bases of altruism, cultural influences, socialization within and beyond the family, and the effect of circumstances. Eisenberg notes that multiple and interacting factors influence children's prosocial responses: the personal characteristics of the individual child (a result of culture, biology, and socialization) will influence the child's interpretation of a specific situation, which will, in turn, affect the intention to assist and the prosocial behavior itself. She argues that no one variable should be considered in isolation, although the difficulty of studying more than one or two of the influences on prosocial development has hampered research in this area.

Shame: The Exposed Self (1992) - Michael Lewis (The Free Press, A Division of Macmillan, Inc., 866 Third Avenue, New York, NY 10022) $24.95.

"The species-specific feeling of shame is central in our lives," argues Michael Lewis. "Shame, more than sex or aggression, is responsible for controlling our psychic course. Shame guides us into depression or antisocial behavior . . . To understand shame is, in some sense, to understand human nature."

Lewis presents a "cognitive attributional" model to describe shame and the other self-conscious emotions, guilt/regret, pride, and hubris (see p. 6, this issue). He notes that because shame is the product of a complex set of cognitive activities, it develops only when a child has the capacity to recognize standards of performance and interprets a failure to meet standards as a global negative evaluation of the self.

Lewis points out that parents who consider themselves "benign socializers of their children" may be unaware of how much they shame and humiliate children. He observes that parents who would never yell at or hit a child frequently exhibit a "disgusted face" when a child does something of which the parent disapproves. This expression might appear only briefly, but children perceive it and turn sharply away. Notes Lewis: "My observation of parents and their children in normal circumstances reveals that disgusted/contemptuous or rage faces that are accompanied by verbal prohibitions occupy at least 40 percent of codable facial expression in parents' behavior. My colleagues and I have seen far too many parent-child relationships we think are in danger because of the overuse of the disgusted/contemptuous face." Love withdrawal as a technique in socialization may also produce shame, since it leads to internal attribution of blame and since it refers to the whole self ("I don't love you"), leading to global attribution of failure.

Reasoning as a socialization technique, notes Lewis, is likely to lead to guilt rather than shame. Reasoning leads children to examine their action and to initiate reparation. Moreover, because reasoning and induction are less intense emotional experiences than the experience of being shamed, children are more apt to attend to the adult's message and, consequently, to adhere to the prescription being offered.

Social Influences and Socialization in Infancy (1991) - Michael Lewis and Saul Feinman, editors (Plenum Publishing Corporation, 233 Spring Street, New York, NY 10013-1578) $49.50.

While issues of social influence (a process through which individuals, groups, and societies are affected by each other) and socialization were downplayed during the formative stages of contemporary infancy research, more recently researchers in the field have begun to turn their attention to these questions. The editors propose that "a sophisticated social-psychological model of socialization and social influence can provide valid insights into virtually the entirety of infant behavior and development."

Unlike earlier behaviorist-psychoanalytic paradigms, current conceptualizations of social influence describe infants playing an active role as "competent and involved participants who are committed to their own socialization." Newer approaches, studying real-life socialization outcomes, pathways, and contexts, take into account parental sensitivity to individual differences, mutuality of influence, and the mediation of socialization outcomes by infants' characteristics and responses. In this volume, Leonard Rosenblum, Alison Clarke-Stewart, Sharon Landesman, James Jaccard, Virginia Gunderson, Judith Dunn, and Michael Lewis address a range of issues, including the effects of environment, sibling influences, and self-knowledge and social influence. A section of the book on processes of influence begins with the most direct methods and moves on to the consideration of ever more indirect mechanisms, in an effort to envision a "comfortable conceptual relationship" between development and socialization. Stimulation, operant-learning mechanisms, and parental control are considered, as well as attachment as a factor in prosocial disposition, infant imitation, and the joint socialization of development by young children and adults. Contributors to this section include Jacob Gewirtz, H. Rudolph Schaffer, John E. Richters, Everett Waters, Ina C. Uzgiris, Barbara Rogoff, and Saul Feinman.

The Psychology of Sympathy (1991) - Lauren Wispe (Plenum Press, A Division of Plenum Publishing Corporation, 233 Spring Street, New York, NY 10013) $34.50.

Drawing on the work of philosophers and of social, cognitive, and neurological researchers from the eighteenth century onward, Lauren Wispe defines sympathy as "the increased sensibility to another person's pain as something to be alleviated." She identifies four phases of a sympathetic response pattern that seem worthy of further investigation:

- First, the perceiver tries to interpret the other person's intentions and state of being through a rapid psychomuscular-anticipatory reaction to very subtle cues;
- Almost simultaneously, there is a rapid scan of the situational factors to which the other person's behaviors may or may not be a reaction;
- Third, there must be some kind of attribution of inner consciousness to the other person ("This is a person like me" or "This person is in pain");
- Finally, there is an attempt to attribute some kind of significance to the totality of events, which then produces the full thrust of the sympathetic process.

Wispe characterizes sympathy as the counteractant to violence in which the victims are relatively helpless, so that the possibilities for controlling aggression must be with the aggressor or with those seeing the aggression. She suggests that in a world "where life necessitates pain, then some capacity like sympathy is necessary to mitigate the suffering ... Sympathy functions as a defense against despair, for despair s the experience that results from the unanswered call for help." The author concludes, however, that the capacity for sympathy is not as strong as the aggressive impulse, "so the study of sympathy needs all the support it can get—from empirical investigation, from psychological theory, and from education."

Character Development: Encouraging Self-Esteem and Self-Discipline in Infants, Toddlers, and Two-Year-Olds (1991) - Polly Greenberg (National Association for the Education of Young Children. 1834 Connecticut Avenue, N.W., Washington, DC 20009-5786) $8.00.

This illustrated volume is designed, says author Polly Greenberg "to encourage those of you who regularly spend many, many hours a week giving care to infants, toddlers, and two-year-olds to appreciate more fully the incredibly important character development work you're doing, and to encourage you to deepen both your understanding of child development and your child caring skills ... If we have been giving culturally appropriate guidance along with our care ..., we have helped build the foundations of good character in each child ... What more could anyone ask of us? What career could be more important?"

The twelve chapters and index are organized so that the volume can be used for reference, browsing, study, and discussion. Many specific guidelines are offered, such as:

- **Assume** that a baby of any age will seek your attention if she needs it. **Assume** that attention span is something to promote. If a baby is busy, don't bother him.
- ... The time out chair as generally used is an example of negative discipline. The teacher dictates, the child doesn't get to use his emerging self-disciplinary skills. Conforming is the goal, not understanding.
- **Biting is such an effective method of getting someone's attention that each time an essentially powerless young child bites and senses the powerful weapons she has stumbled upon, the behavior is strongly reinforced** (emphasis in original) ... In group care, biting has to be stopped as soon as humanly possible; it can't be tolerated ... Every intended bite must be intercepted.
- The young child should not have to "be good" to "earn" indicators of caregivers' enjoyment. Children should freely be given affection and approval solely because they **exist.**

Scenes from Day Care: How Teachers Teach and What Children Learn (1992) - Elizabeth Balliet Platt (Teachers College Press, 1234 Amsterdam Avenue, New York, NY 10027) $16.95.

"By looking in detail at what actually happens to children in specific situations, perhaps we can identify the kind of positives that we want to build on as well as the negatives we need to avoid or change in our children's day care experience," suggests Elizabeth Balliet Platt. An educator-filmmaker, Platt decided to film free times, project times, circle times, mealtimes, nap times, and the transitions between in a broad spectrum of child care centers in the United States and Europe. She was looking for "illuminating or successful exchanges" between teachers and children; recognizing that she would not understand at first what "the best situation" looked like, particularly in unfamiliar cultures, she tried to suspend judgment as much as possible during filming, reviewing and assessing footage afterwards.

The vignettes recorded in this volume are organized around the themes of the day care day, self-control, children's protests, crying (as communication), and social values. A chapter called "A Teacher's View" describes one teacher's way of organizing the experience of the infants and toddlers in her care, and her feelings about her work. In each chapter, Platt draws conclusions from the material she has presented and includes, in an "other voices" section, selections from the work of other writers on child development and child care. Platt concludes, "How children are responded to is more important, with more impact on learning, than the actual content of programs."

The House of Make-Believe: Play and the Developing Imagination (1990) - Dorothy G. Singer and Jerome L. Singer (Harvard University Press, 79 Garden Street, Cambridge, MA 02138) $29.95.

As psychologists who are both behavioral scientists and clinicians, Dorothy Singer and Jerome Singer describe the essays that make up this volume as combining a scientific and a humanistic approach to the exploration of the origins, determinants, and manifestations of the human imagination in childhood and early adolescence. They intersperse their review of theoretical issues and formal research findings with personal recollections, literary accounts, and clinical observations.

Discussing the play of infants and toddlers, the authors emphasize the blending of three facets of the child's development—constitutional factors, the influence of the caregiver's personality traits and style, and the combined effect of these components on the baby's emerging cognitive skills. They note the importance to young children of a person who plays and encourages play; places, space, and time for play; and props and pets ("None are more compelling or conducive to make-believe and fantasy than the books children read or hear read to them by a warm, loving adult.") "When children can play openly and freely," note the authors, "they become good learners, developing their cognitive skills through the stepping-stones of play."

The Collaborative Construction of Pretend: Social Pretend Play Functions (1992) - Carollee Howes, with Olivia Unger and Catherine C. Matheson (State University of New York Press, State University Plaza, Albany NY 12246) $16.95.

The authors of this book argue that social pretend play can fulfill several different developmental functions and that these functions change with development: the task for toddlers is mastery of communication of meaning within social pretend play, while the task of older children is the integration of social pretend play. Social pretend play is seen as salient in the formation of both social interaction skills and friendships from the toddler period into middle childhood, but there are changes in both the forms and the functions of social pretend play across these periods. Howes and her co-authors identify three functions of social pretend play:

- the communication of meaning through mastery of social pretend forms (in the toddler period);
- expressing and exploring issues of control and compromise by negotiating social pretend play meanings and scripts (in the early preschool period); and
- exploring issues of intimacy and trust within social pretend play (in older children).

Although she argues that social pretend play fulfills a single most important function during each developmental period, she does not imply that such play has only one function within an age period; she notes, for example, that toddlers do form friendships and that toddler social pretend play may serve intimacy functions.

The authors further suggest that the social pretend play partner is important in understanding the functions of social pretend play. Mastery functions are enhanced by more expert partners and by partners who are sensitive to the child's attempts to communicate. Harmonious negotiations and intimacy and trust functions are influenced by the relationships between play partners: children who are friends may be more likely to resolve issues of autonomy and control successfully, and to use social pretend play to explore intimacy and trust.

In this volume, review chapters on each of the three social pretend play functions listed above are followed by several illustrative studies. For example, the studies of toddlers include a comparison of toddlers' independent symbolic play with collaborative symbolic play between toddlers and mothers; description and comparison of the efficacy of strategies used by toddlers to construct social pretend play with their peers; and an examination of the play dialogues of American and Mexican three year-olds.

Developing Cross-Cultural Competence (1992) - Eleanor N. Lynch and Marci J. Hanson, editors (Paul H. Brookes Publishing Company, P.O. Box 10624, Baltimore, MD 21285-0624) $32.00.

This 377-page book emphasizes the importance of intervention that is culturally sensitive and suggests specific skills that interventionists can learn and incorporate into their practice to increase their cross-cultural competence. The editors note that "recognition of the transactional and/or situational nature of cultural identity may be the most important point to consider in working with families from a variety of cultures. This point guides the interventionist away from over-generalizing about families or stereotyping families based upon their cultural background ... Acceptance of the constant dynamic interplay of the individual's beliefs and background with the daily demands of the society ... will guide interventionists to greater understanding and sensitivity in their work with families."

The authors stress the importance of self-awareness as a beginning point for cross-cultural competence, noting the need to learn about one's own culture, weed out prejudices, and understand the profound impact of culture on all aspects of life. Specific strategies are offered for learning culture-specific information and practicing new communication strategies. For example, a section on working with interpreters and translators, contributed by Samuel Q. Chan, describes characteristics of effective interpreters, cautions and concerns related to the use of family members or non-family members as interpreters, interpreters and stress, and guidelines for working with an interpreter.

JOHN DAVID ARMS

The book introduces the reader to a number of the major cultural and ethnic groups that make up the U.S. population. Contributing authors who describe these groups were selected for their dual expertise and knowledge of the culture, and their experience in working with families of children who are at risk or disabled. Described in terms of their history, values, and beliefs, with particular emphasis on issues related to the family, childrearing, and disability, are families with Anglo-European, Native American, African American, Latino, Asian, Pilipino, Native Hawaiian and Pacific Island, and Middle Eastern roots.

The Child's Point of View (Second Edition) (1991) - Maureen V. Cox (The Guilford Press, 72 Spring Street, New York, NY 10012) $49.95, hardcover; $18.95, paper.

The development of an awareness and understanding of other points of view, whether it be through greater sensitivity or more advanced cognitive functioning, is important, the author of this volume reminds us, if we are to operate efficiently and effectively in our social and natural environment. Challenging the notion that children are egocentric, Maureen Cox addresses four topics: 1) the development of visual perspective-taking; 2) the artist's point of view; 3) conversational role-taking; and 4) children's understanding of people's mental states.

Cox finds abundant evidence that young children below the age of four years have a considerable understanding of other observers and other views, especially when adults offer verbal and non-verbal cues to focus a child's attention. She observes that very young children make inferences concerning the points of view of their conversational partners: in one study, two-year-olds distinguished whether or not their listeners were attending to them, and modified their conversational gambits accordingly. Cox notes that by the end of their first year, infants have some understanding of the meaning of universal facial expressions of such basic emotions as happiness, anger, and sadness. During their second year, they become more active and make attempts to *alter* the emotional states of others. She suggests that toddlers' understanding of how other people feel may be related to their capacity for pretense, enabling them to imagine how someone feels without, at the same time, having to experience that emotion themselves. By the age of three years, she finds, children can work out that different people may feel different things, even when confronted by the same situation. It is not until the age of about six years, however, that children begin to be able deliberately to mislead others as to their true feelings.

When Home Is No Haven: Child Placement Issues (1992) - Albert J. Solnit, M.D., Barbara F. Nordhaus, and Ruth Lord (Yale University Press, 92A Yale Station, New Haven, CT 06520) $20.00.

This volume is a casebook, designed to be of practical value to professionals involved in various aspects of child placement. It emphasizes the decision-making process involved in responding to the challenges of child neglect and abuse. The authors recognize that in too many instances, "good" resolutions may not, in fact, exist—a circumstance that necessitates the application of the principle of "the least detrimental alternative." The authors also stress a developmental view of children's needs. As Albert Solnit noted in an earlier work with Goldstein and Freud:

> Emotional attachments in early life form the bedrock of all subsequent attachments. For these relationships to be internalized and elaborated, the child needs the stability that is reflected in external continuity and permanency. ... From birth to about 18 months, even a shift in routine may cause discomfort, but the most serious effect on the emotional development of infants and toddlers results from a change of the primary caretaking person. When separated from a familiar adult, young children suffer not only distress but also setbacks in the quality of their ensuing attachments. ... Subsequent attachments to new caretakers may reach previous levels of trustfulness and enrichment, reflecting infants' intense needs for adults who will love and take care of them. Nevertheless, multiple placements in the early years may lead to increasingly shallow and indiscriminate attachments.

The 35 illustrative cases discuss children who are removed from home, children who are returned home, children who remain at home or are returned home with support services, and other issues such as visitation conflicts and sibling placement. Eighteen of these cases involve infants and toddlers. The authors acknowledge the complexity and stress of protective services

caseworkers' roles and urge that supervision and consultation be available on a regular basis.

Improving Children's Lives: Global Perspectives on Prevention (Primary Prevention of Psychopathology, Vol. XIV) (1992) - George W. Albee, Lynne A. Bond, Toni V. Cook Monsey, editors (Sage Publications, Inc., 2455 Teller Road, Newbury Park, CA 91320) $39.95.

This book grew in large part from the fifteenth Vermont Conference on the Primary Prevention of Psychopathology, convened in June, 1990 with support from the National Institute of Mental Health, the MacArthur Foundation, and the University of Vermont. Conference speakers came from a variety of national and international groups active in efforts to improve children's lives. The editors note that "the problems, both physical and psychological, afflicting the world's children are so vast as to numb the mind ... For a number of social, cultural, and political reasons, nations have invested fewer of their economic resources in programs to ensure healthy babies and children than in ... areas that have greater appeal to politicians in male-dominated governments."

Among the chapters concerned specifically with infants, toddlers, and their families are an epidemiological study of mental disorders during early childhood in the Soviet Union, by Olga Bazhenova and her colleagues; a longitudinal study of children born from unwanted pregnancies in Czechoslovakia, by Zdenek Dytrych; a review of India's Integrated Child Development Scheme, a multimodal approach to intervention, by Nomita Sonty; and an analysis of a range of preventive projects, including outreach efforts to immigrant families, undertaken by community mental health centers in the Netherlands.

Conference Call:

May, 1992

May 21-22: *Beginnings Early Intervention Services*, the Pennsylvania Chapter of the *American Academy of Pediatrics*, and *Project Caring* will sponsor a conference in Pittsburgh, Pennsylvania on "Creating Family-Professional Partnerships: Educating Physicians and Other Health Professionals to Care for Children with Chronic and Disabling Conditions." Keynote speakers are Florene Poyadue and Alfred Healy. Contact Beginnings at 406 Main Street, Suite 201, Johnstown, PA 159-1, tel: (814) 539-1919.

May 30: The *Reginald S. Lourie Center for Infants and Young Children* and the Center's *Cecil and Ida Green Research and Training Institute* will sponsor a training symposium in Rockville, Maryland, entitled "Drug-Exposed Babies: A National Crisis, A National Opportunity. Speakers will include Barry Zuckerman, Margot Kaplan Sanoff, Carol Brooks, Alison Marshall, Rose Queen, Joseph Sherman, Angela Herring, Felicia Valdez, Shirley Coletti, Diane Powell, and Georgia DeGangi, among others. Contact the Lourie Center, 11710 Hungers Lane, Rockville, MD 20852, tel: (301) 984-4444.

ROBERT MAUST

June, 1992

June 3-6: The *National Institute for Early Childhood Professional Development* of NAEYC will hold a working conference in Los Angeles, CA entitled "The Early Childhood Profession Coming Together." Its purpose will be to address issues of content, policy, and delivery systems related to the implementation of an artiulated professional development system for the field of early childhood education. A post-conference technical assistance workshop will be offered by the Wheelock Center for Career Development in Early Care and Education. Contact the National Institute for Early Childhood Professional Development, NAEYC, 1834 Connecticut Avenue, N.W., Washington, DC 20009, tel: (202) 232-8777 or (800) 424-2460, FAX: (202) 328-1846.

June 15-17: The *Centers for Disease Control (CDC)* and 14 other organizations, including the *National Center for Clinical Infant Programs*, will co-sponsor a conference in Atlanta, Georgia, entitled "International Child Day Care Health: Science, Prevention, and Practice." Speakers will include William H. Foege, Carollee Howes, Linda Randolph, George Stern, Al Chang, Susan Aronson, Michael Osterholm, Bettye Caldwell, Herbert Cohen, Judy Calder, William Roper, Pauline Koch, Abby Shapiro Kendrick, and Barbara Bergmann. Contact Lisa Townsend at Pace Enterprises, Inc., tel: (404) 633-8610, fax: (404) 633-8745.

June 15-19: The *College for Human Development and Division of Summer Sessions of Syracuse University* will sponsor Alice Honig's 16th Annual Quality Infant/Toddler Caregiving National Workshop in Syracuse, New York. Faculty will

include Alice Honig, William Fowler, Andrea Monan, Susan Snyder, Mary Anne Theiss, Thomas Fiscoe, and John Friedman. Write or call Alyce Thompson, College for Human Development, Dept. of Family and Child Studies, 201 Slocum Hall, Syracuse, NY 13244-1250, tel: (315) 443-2757.

June 23: The *Youth Development Clinic* will sponsor a seminar in Newark, New Jersey on "Infant Mental Health and the Infant-Parent Relationship: Implications for Early Intervention Programs." Instructors will be Gerard Costa, Thea Bry, and Ruth Edelman. Contact YDC, 303-309 Washington Street, Newark, NJ 07102, tel: (201) 623-5080.

June 24-26: *Contemporary Forums* will hold a conference in San Diego, California on clinical issues and trends in intervention for developmentally delayed infants and children. For information, contact Contemporary Forums, 11900 Silvergate Drive, Suite A, Dublin, CA 94568, tel: (510) 828-3300.

June 24-26: The fifth annual *Bank Street College of Education Infancy Institute*, entitled "Infants, Toddlers, Parents: Supporting Their Growth," will be held in New York City. Bettye Caldwell will be the keynote speaker. All-day seminars on observing infants and toddlers and working with families of varied cultures will be offered. Contact Dr. Nancy Balaban or Dr. Virginia Casper, Bank Street College of Education, 610 West 112th Street, New York, NY 10025, tel: (212) 222-6700, x 410 or 335.

NANCY P. ALEXANDER

July, 1992

July 13-17: The *United States-Israel Binational Science Foundation* and *Wheelock College Graduate School* will sponsor the second binational workshop on "Play and Cognitive Ability: The Cultural Context" in Boston, Massachusetts. Presenters will include Sara Smilansky, Carol Seefeldt, Vivian Paley, Rina Michalovitz, Edgar Klugman, Patricia Monighan-Nourot, Doris Fromberg, and Leah Shefatya, among others. For information, contact Play Workshop, Wheelock College, 200 The Riverway, Boston, MA 02215, tel: (617) 734-5200, x 139.

July 18-22: The *Child and Adolescent Service System Program (CASSP) Technical Assistance Center* at the Georgetown University Child Development Center will sponsor training institutes in Breckenridge, Colorado on developing local systems of care for children and adolescents who are severely emotionally disturbed. Early intervention will be the topic of one specialty institute. Contact the CASSP Technical Assistance Center, 2233 Wisconsin Avenue, NW, Washington, DC 20007, tel: (202) 338-1831.

July 31 - August 2: The *Fifth Biennial NCAST Institute*, entitled "Understanding Differences: Intervention for Promoting Relationships and Communication," will be held in Bellevue, Washington. The Institute will focus on working with adolescents and with culturally diverse populations. Speakers will include Kathryn Barnard, Noel Chrisman, Laura Kastner, Harriet Kitzman, Alicia Lieberman, Colleen Morisett, and Molly Reid. Contact NCAST, University of Washington, WJ-10, Seattle, WA 98195, tel: (206) 543 8528, Fax: (206) 685-3284.

September, 1992

September 8-15: The *University of California Irvine, Division of Neonatal/Perinatal Medicine and Infant Care Specialists* will hold a conference in Newport Beach, California entitled "The New Decade: Neonatal Developmental Follow-up and Multidisciplinary Care." Claudine Amiel-Tison will be a featured presenter. Contact Cheryl Milford or Marc Lerner, Division of Neonatology, University of California, Irvine, Medical Center Bldg. 29!, Rt.81, 101 The City Drive South, Orange, CA 92668, tel: (714) 456-6933.

September 9-13: The *World Association of Infant Psychiatry and Allied Disciplines* will hold its Fifth World Congress in Chicago, Illinois, on the theme "A Future for Babies: Opportunities and Obstacles." For information, contact Jo Cohn Sawyer, 2 N. LaSalle, Suite 605, Chicago, IL 60602-3703, tel: (312) 621-0670, Fax: (312) 621-0377.

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